NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

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

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

BOARD OF DIRECTORS

Supervisor Andrew Do, Chair	Isabel Becerra, Vice Chair
Clayton Chau, M.D.	Clayton Corwin
Mary Giammona, M.D.	Victor Jordan
J. Scott Schoeffel	Supervisor Michelle Steel
Trieu Tran, M.D.	Vacant

Supervisor Doug Chaffee, Alternate

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 (415) 655-0052 Access Code: 163-293-819 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/7664969746423515915 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 Rx Transition Delay
   b. COVID-19 Update
   c. Supreme Court Hearing on Affordable Care Act
   d. Behavioral Health Integration Incentive Program
   e. Homelessness Learning Community
   f. CalOptima PACE Media Coverage
   g. Cal MediConnect Transition
   h. Proposed Foster Youth Medi-Cal Plan
   i. California Health Care Foundation Health Care Leadership Program

2. COVID-19 Update

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

CONSENT CALENDAR
3. Minutes
   a. Approve Minutes of the November 5, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the September 17, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the Minutes of August 13, 2020 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee; the Minutes of the September 10, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the Minutes of the October 8, 2020 Joint Meeting of the CalOptima Board of Directors' Member Advisory, OneCare Connect Member Advisory, the Provider Advisory, and the Whole-Child Model Family Advisory Committees

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

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

6. Consider Authorizing an Amendment to the Amended and Restated Development Agreement with the City of Orange to Extend CalOptima's Development Rights

7. Consider Approval of Proposed Revisions to CalOptima's Operations Policies and Procedures

8. Consider Authorization of the Reallocation of Budgeted but Unspent Salary Dollars to Expand the Scope of Work of a Contract for External Peer Review Services Contract and Extend a Contract for Medical Consulting Services

9. Consider Approval of Actions Authorizing Extensions and Other Modifications of Whole Person Care Agreements with the Orange County Health Care Agency

10. Consider Authorization of Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2020–2021 Capital Budget

11. Consider Ratifying Contract with Chapman Consulting for Consulting Services related to the 2020-2022 Strategic Plan

12. Consider Approval of Modifications to Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N

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

14. Consider a New Letter of Commitment for Medi-Cal Supportive Services in Connection with a Grant Award to American Family Housing under the Housing for a Healthy California Program

15. Receive and File:
    a. September 2020 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

REPORTS

16. Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates

17. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business

18. Consider Authorizing Amendments to the Medi-Cal Shared-Risk Physician Group, Physician Hospital Consortium, and Health Maintenance Organization Health Network Contracts, Except Kaiser Foundation Health Plan, Inc.

19. Consider Approval of Modification to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

20. Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives

21. Consider Authorizing Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2021

22. Consider Authorizing Amendment to Ancillary Contract with the Illumination Foundation

23. Consider Adoption of Resolution Approving Revised CalOptima 2021 Compliance Plan and Authorizing the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures

24. Consider Approval of Modifications to CalOptima Policy FF.1007: Health Network Reinsurance Coverage and FF.4000 Whole-Child Model – Financial Reimbursement for Capitated Health Networks

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

26. Consider Election of Officers of the CalOptima Board of Directors

ADVISORY COMMITTEE UPDATES

27. OneCare Connect Member Advisory Committee Update

28. Whole-Child Model Family Advisory Committee Update

29. Provider Advisory Committee Update

30. Member Advisory Committee Update

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS-1. Pursuant to Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Long Beach Memorial Medical Center, et al. v. CalOptima et al. (Orange County Superior Court (OCSC) Case No. 30-2019-01046530-CU-CO-CJC) and

CS-2. Pursuant to Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Long Beach Memorial Medical Center, et al. v. CalOptima et al. (OCSC Case No. 30-2020-01141526-CU-BC-CJC)

CS-3. Pursuant to Government Code Section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Property: 13300 Garden Grove Blvd, Garden Grove, CA 92843
Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Young S. Kim and Soon Y. Kim
Under Negotiation: Price and Terms of Payment

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on December 3, 2020 2:00 PM PDT at: https://attendee.gotowebinar.com/register/7664969746423515915
2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:

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

   --OR--

   TO USE YOUR TELEPHONE:

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

   United States: (415) 655-0052

   Access Code: 163-293-819

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	November 24, 2020
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, CEO
SUBJECT:	CEO Report — December 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

Medi-Cal Rx Transition Is Delayed Until April 1, 2021

On November 16, the Department of Health Care Services (DHCS) notified managed care plans that the transition to the Medi-Cal Rx fee-for-service pharmacy delivery system would move from January 1, 2021, to April 1, 2021. In the interim, all current prescription drug processes and protocols will remain in place. The three-month delay provides more time to ensure a smoother, more complete transition for Medi-Cal members during the pandemic, according to DHCS. In response to the news, CalOptima launched efforts to notify our provider community:

- Health networks were informed in their weekly email communication.
- A Provider Alert was sent to providers via fax blast.
- Provider announcements were posted to the CalOptima website.
- Attendees at the November 19 Health Network Forum received an update.

Members had already received two notices from the state in October and November and were due to get a 30-day notice from CalOptima. In early December, DHCS, in partnership with Magellan, will send a revised member notice to all Medi-Cal members explaining the new Medi-Cal Rx launch date. The state has directed all plans to update their 30-day notices with the new implementation timeline and distribute them no later than March 1, 2021.

Orange County Moves to More Restrictive Tier; CalOptima Participates in Vaccine Group

Orange County transitioned to the more restrictive Purple Tier (Widespread Risk) of California's Blueprint for a Safer Economy on November 16. To support efforts to slow the spread of COVID-19, CalOptima shared information with the community via our social media channels and with our employees via internal communications. As of November 23, 3,626 positive cases, 2,108 hospitalizations and 338 deaths have been reported among CalOptima members. In the meantime, news about promising vaccines from three companies has made recent headlines. Locally, the Orange County Health Care Agency (HCA) has created a COVID-19 Vaccine Taskforce of community leaders and medical experts, including CalOptima Chief Medical Officer David Ramirez, M.D. This group will address prioritization of vaccine recipients, respond to vaccine concerns, and make recommendations to the HCA staff and director. Further, the agency asked for assistance from taskforce members with promoting community participation in a COVID-19 vaccine survey, so CalOptima shared the survey link widely.

Supreme Court Holds Hearing on Affordable Care Act

On November 10, the U.S. Supreme Court heard oral arguments in the case of *California v. Texas*, which examines the constitutionality of the Affordable Care Act (ACA) following the

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repeal of the individual mandate penalty fee through the Tax Cuts and Jobs Act of 2017. A preliminary analysis from the Association for Community Affiliated Plans projects that the ACA will be upheld, even if the individual mandate statute is removed from the ACA. The Supreme Court is expected to issue a final decision by June 2021. CalOptima has more than 250,000 members who are covered under the ACA's expansion of Medicaid (Medi-Cal).

New Behavioral Health Integration Program Boosts Funding for Orange County Services
CalOptima has been awarded $13.2 million to enhance mental health services in Orange County through the state's Behavioral Health Integration (BHI) Incentive Program. In 2019, DHCS created the Proposition 56-funded BHI Incentive Program to reward efforts in six specific areas (see below) and required Medi-Cal managed care plans to complete administrative, review and oversight tasks on its behalf. By February 2020, CalOptima had made significant progress in identifying program participants. However, the pandemic caused the state to delay further action until late summer, when it announced tentative approval of 12 projects in Orange County. In early November, DHCS gave official approval of those projects from seven organizations. CalOptima will develop agreements with the organizations for the two-year program, from January 1, 2021, to December 31, 2022. The six incentive program areas are: basic behavioral health integration, maternal access to mental health and substance use disorder screening and treatment, medication management for beneficiaries with co-occurring chronic medical and behavioral diagnoses, diabetes screening and treatment for people with Serious Mental Illness, improving follow-up after hospitalization for mental illness, and improving follow-up after emergency department visit for behavioral health diagnosis.

Homelessness Learning Community Selects CalOptima for Participation
After a competitive application process, CalOptima was selected to participate in the California Health Care and Homelessness Learning Community. Described here, the statewide community is overseen by the Center for Health Care Strategies and the California Health Care Foundation. The community was created with two tracks: one for managed care plans and another for providers. Both tracks will meet separately in the same month to address the same topic and then come together the following month to discuss what was shared. Among the community's goals are exploring opportunities to address the health care needs of individuals experiencing homelessness under California Advancing and Innovating Medi-Cal (CalAIM), identifying high-priority areas for response and connecting stakeholders to relevant innovations for accelerated implementation. The first meeting of the one-year effort was November 20, and CalOptima looks forward to gathering information to advance our local Homeless Health Initiatives.

CalOptima Program of All-Inclusive Care for the Elderly Featured on TV, Radio
The CalOptima Program of All-Inclusive Care for the Elderly (PACE) was featured on television and radio this month. On November 18, ABC 7 ran a segment during the 6 p.m. news that highlighted PACE's efforts to keep participants safe during the pandemic by delivering services in the community. Working with CalOptima's Communications team, reporter Tony Cabrera included video of PACE participant Patrick McGee and a Zoom interview with PACE Director Elizabeth Lee in the piece. Separately, Ms. Lee and PACE Medical Director Miles Masatsugu, M.D., were interviewed by broadcaster Tammy Trujillo for Angels Radio (AM 830). Trujillo's KLAA Community Cares program, which aired November 22, also covered PACE's approach to serving seniors amid the pandemic.

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State Begins Considering Plans for a Cal MediConnect Transition
DHCS officials recently convened a Cal MediConnect (CMC) Enrollment Transition Workgroup with participants from the Centers for Medicare & Medicaid Services and CMC plans, including CalOptima's OneCare Connect. The goal is to prepare for a transition when CMC plans are due to end on December 31, 2022. The regulators are seeking preliminary input and feedback before following up with a broader stakeholder engagement effort. Simultaneously, CalOptima is also planning for the anticipated transition and will engage stakeholders to consider the impact on members and providers should OneCare Connect not be extended past 2022.

Single Medi-Cal Plan for Foster Youth Members to Be Proposed
Regulators are considering the option of a single, statewide managed care plan for foster youth. If implemented, the program would likely be managed by a commercial health care plan. Because this could impact approximately 8,000–10,000 CalOptima members, we have been sharing best practices from our successful plan-managed program for foster youth with our state associations, Local Health Plans of California and California Association of Health Plans. Through the associations, CalOptima is advocating for the continued enrollment of foster youth in managed care plans, emphasizing the importance of local relationships with organizations that serve foster youth. Such connections enable plans to quickly resolve access and eligibility issues. DHCS is expected to release a draft proposal in the next few months.

CalOptima Health Care Informatician Chosen for Statewide Leadership Program
Congratulations to Marie Jeannis, RN, MSN, Director, Enterprise Analytics, who has been accepted to the California Health Care Foundation Health Care Leadership Program Cohort 20. Selection for this statewide fellowship is competitive, with an application and interview process. The two-year program provides clinically trained professionals with opportunities to further develop leadership in the health care system. CalOptima now has two leaders in the program (Ms. Jeannis and Edwin Poon, Ph.D., Director, Behavioral Health Integration, in his second year) and two alumni (Betsy Ha, RN, Executive Director, Quality and Population Health Management, and Miles Masatsugu, M.D., PACE Medical Director).

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2. COVID-19 Update

This will be a verbal update

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

November 5, 2020

A Regular Meeting of the CalOptima Board of Directors was held on November 5, 2020, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:00 p.m. and Director Schoeffel led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chair; Isabel Becerra, Vice Chair; Jackie Brodsky; Clayton Chau (non-voting) (at 2:08 p.m.); Clayton Corwin; Mary Giammona, M.D. (at 2:08 p.m.); Victor Jordan; Scott Schoeffel; Supervisor Michelle Steel (at 2:08 p.m.); Trieu Tran, M.D. (at 2:08 p.m.)
(Director Chau; Director Giammona; Supervisor Steel; Director Tran participated remotely)

Members Absent: None

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

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Richard Sanchez, Interim Chief Executive Officer, highlighted several items from his report including: Homeless Health Initiatives and Network Certification and Medical Audit. With regard to the Homeless Health Initiatives, Mr. Sanchez noted that COVID-19 has impacted CalOptima's efforts to ensure that homeless members have access to health care services, including the clinical field teams. In light of these changed circumstances, staff will be returning to the Board with further recommendations on expenditures of the remaining balance of the $100 million allocated for healthcare services for members experiencing homelessness. Regarding network certification, Mr. Sanchez noted that CalOptima completed its annual network certification for 2020 without any deficiencies; however, the Department of Health Care Services (DHCS) noted that starting in July 2022, CalOptima's health networks will also need to meet all standards for number and mix of primary and specialty providers, time and distance, service availability, physical accessibility, and other standards.

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The Board asked for regular status reports on the progress of CalOptima's health networks in meeting the new requirements.

2. COVID-19 Update
David Ramirez, M.D., Chief Medical Officer, provided an update on CalOptima's COVID-19 response efforts.

3. Election 2020 Review and Federal Policy Outlook
Josh Teitelbaum, Senior Counsel and Heide Bajnrauh, Senior Policy Advisor, at Akin Gump Strauss Hauer & Feld LLP, provided a review of the 2020 election results and a Federal Policy Outlook for 2021.

PUBLIC COMMENTS

1. Gio Corzo, Meals Orange on Wheels – Oral re: Opposition to Innovative Integrated Health (IIH) opening a PACE facility in Orange County
2. Holly Hagler, Meals on Wheels – Oral re: Opposition to Innovative Integrated Health (IIH) opening a PACE facility in Orange County

CONSENT CALENDAR

4. Minutes
   a. Approve Minutes of the October 1, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the August 27, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

5. Consider Authorizing and Directing Execution of a New Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly
Staff noted a correction to the Fiscal Impact section date references of June 30, 2020, and July 1, 2020, which should both be 2021 rather than in 2020.

6. Consider Authorizing and Directing Execution of Amendments to CalOptima's Primary and Secondary Agreements with the California Department of Health Care Services

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

8. Consider Approval of Various Policy Changes in Response to Medi-Cal Pharmacy Carve Out (Medi-Cal Rx)

9. Consider Approval of Modifications to Policy EE.1127: Disposable Incontinence Supplies Network and EE.1135: Long Term Care Facility Contracting

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10. Consider Authorization of a Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term

11. Receive and File
    a. September 2020 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

Consent Calendar Agenda Item 10 was pulled for discussion.

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors approved the balance of the Consent Calendar, with the correction noted for Consent Calendar Agenda Item 5, as presented. (Motion carried 9-0-0)***

10. Consider Authorization of a Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Director Jordan noted that CalOptima staff seems to have been reasonable in their approach with Kaiser and efforts to get the contract finalized. He also expressed concern with the delay and asked what steps would be implemented to minimize disruptions to member care in the event that CalOptima and Kaiser are unable to come to an agreement.

Mr. Sanchez responded that CalOptima is still in discussion with Kaiser, explaining that Kaiser has not yet agreed to comply with CalOptima policies as part of CalOptima's oversight of Kaiser as required by the Department of Health Care Services (DHCS) for CalOptima's subcontracted entities. In some parts of the State, Kaiser has a direct contract with DHCS, and in the past, Kaiser had a three-way contract with CalOptima and DHCS, which minimized CalOptima's oversight. However, in Orange County, Kaiser is a CalOptima subcontractor for the Medi-Cal members CalOptima assigns to Kaiser, and the prior three way agreement is no longer in effect. In addition, with CalOptima's recent risk adjustment exercise, Kaiser's capitation will be based on patient acuity in the same manner that rates are set for all the other CalOptima Health Networks. Mr. Sanchez also noted that CalOptima's other health networks would be willing and able to ensure that these members would continue to have access to the health care services they need if an agreement cannot be reached with Kaiser.

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors authorized an amendment to the current Kaiser Foundation Health Plan, Inc. Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, December 3, 2020. (Motion carried 8-0-0; Director Schoeffel absent)***

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REPORTS

12. Consider Authorizing Extension and Amendments to the OneCare Health Network Contracts

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors authorized the Chief Executive Officer with the assistance of Legal Counsel, to amend the OneCare Health Network contracts to extend the contract through December 31, 2021 and to address modified and additional terms. (Motion carried 7-0-1; Chair Do abstained; Director Schoeffel absent)***

13. Consider Authorizing Extension of, and Amendments to, the Cal MediConnect (OneCare Connect) Health Network Contracts

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Connect Health Network contracts to extend the term through December 31, 2021 and to address modified and additional terms. (Motion carried 7-0-1; Chair Do abstained; Director Schoeffel absent)***

14. Consider Authorizing Reallocation of Intergovernmental Transfer Funds Previously Allocated for Housing Supportive Services; Consider Authorizing a Letter of Commitment and Grant Agreement with the County of Orange for the Homekey Program

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors: 1.) Authorized reallocation of $2.5 million in Intergovernmental Transfer (IGT) 6 and 7 funds allocated for housing supportive services to the County of Orange's Homekey Program for CalOptima Medi-Cal members; 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to: a.) Issue a commitment letter to the County of Orange to provide $2.5 million in grant funds for the County's Homekey Program in exchange for at least three years of enhanced services provided to CalOptima Medi-Cal members at the Homekey Program sites; and b.) Enter into a Grant Agreement with the County of Orange to provide $2.5 million in grant funds for the County's Homekey Program initiative in exchange for at least three years of enhanced services provided to CalOptima Medi-Cal members at the Homekey Program sites. (Motion carried 8-0-0; Directors Schoeffel absent)***

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15. Consider Authorizing Amendment to Extend Contract and Update Terms with National Committee for Quality Assurance (NCQA)-Certified Vendor Inovalon for Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Support

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with Inovalon to update product terminology consistent with the vendor's move to a cloud-based platform and include an additional one year extension option through October 31, 2025 exercisable at CalOptima's sole discretion. (Motion carried 8-0-0; Directors Schoeffel absent)***

16. Consider Appropriating Funds and Authorizing Expenditures to Enhance CalOptima's Program of All-Inclusive Care for the Elderly Marketing Efforts

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

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors, appropriated up to $228,000 in unbudgeted funds from existing reserves and authorized the Chief Executive Officer to make expenditures of these funds to support enhanced marketing efforts for the CalOptima Program of All-Inclusive Care for the Elderly through June 30, 2021. (Motion carried 8-0-0; Directors Schoeffel absent)***

Chair Do announced that Agenda Item 17 would be considered after Closed Session.

ADVISORY COMMITTEE UPDATE

18. Joint Meeting Update of the Member Advisory, OneCare Connect Member Advisory, Provider Advisory, and Whole-Child Model Family Advisory Committees

Christine Tolbert, MAC Chair, provided an overview of the joint meeting of the CalOptima Member Advisory, OneCare Connect Advisory, Provider Advisory, and Whole-Child Model Advisory Committees held on October 8, 2020. Ms. Tolbert also extended an invitation to Board Members to attend one or more of the Advisory Committee or Joint Advisory Committee meetings.

CLOSED SESSION

The Board of Directors adjourned to closed session at 3:40 p.m. pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE APPOINTMENT (Chief Executive Officer); pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); and Pursuant to Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATIORS Agency Designated Representatives: (Andrew Do, Chair; Isabel Becerra, Vice Chair) Unrepresented Employee: (Chief Executive Officer).

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The Board reconvened to open session at 4:41 p.m. and the Clerk re-established a quorum.

ROLL CALL

Members Present: Supervisor Andrew Do, Chair; Isabel Becerra, Vice Chair; Jackie Brodsky; Clayton Corwin; Mary Giammona, M.D.; Victor Jordan; Scott Schoeffel; Supervisor Michelle Steel; Trieu Tran, M.D.
(Director Giammona; Supervisor Steel; Director Tran participated remotely)

Members Absent: Clayton Chau (non-voting)

17. Consider Approval of Executive Employment Agreement Terms and Authorization of Execution of Executive Employment Agreement/Employment Agreement Amendment (Chief Executive Officer)

Chair Do reported that after discussion in Closed Session the Board appointed Richard Sanchez to serve as CalOptima's Chief Executive Officer.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors appointed Richard Sanchez as CalOptima's Chief Executive Officer. (Motioned carried 8-0-1; Director Jordan abstained)***

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors 1) approved Richard Sanchez' Executive Employment Agreement, that includes the following: a.) an annual base salary of $409, 249.00 payable in equal installments; b.) employee will be eligible for annual incentive compensation of up to 20% of current base salary; c.) employee will receive a monthly car allowance of $550; d.) employer will pay for employee's CalPERS ("PERS") retirement contribution and supplemental Public Agency Retirement System ("PARS") contributions up to the maximum amount permitted by applicable law; e.) employer will provide term life insurance in the amount of two (2) times employee's annual salary; and f.) employee shall accrue paid time off (PTO) at a rate of 33 days per year (prorated on a bi-weekly basis), and authorized the Chair to execute the Executive Employment Agreement on behalf of CalOptima. (Motion carried 7-1-1; Director Jordan abstained and Supervisor Steel voting no)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Jackie Brodsky announced her resignation from the CalOptima Board of Directors. Board Members thanked Director Brodsky for her service and contributions. Board Members congratulated Mr. Sanchez on his appointment as CalOptima's permanent Chief Executive Officer.

ADJOURNMENT

Hearing no further business, Chair Do adjourned the meeting at ~~4:00~~ 4:55 p.m.

Rev. 5/3/2023

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: December 3, 2020

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 17, 2020

A Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee was held on September 17, 2020 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER
Chair Isabel Becerra called the meeting to order at 2:03 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Isabel Becerra, Chair; Clayton Corwin (at 2:55 p.m.); Scott Schoeffel
(All members at teleconference locations)

Members Absent: None

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

PUBLIC COMMENTS
There were no requests for public comment.

Chair Becerra reordered the agenda to hear Information Item 11. before Management Report 1.c. and to hear Report Item 10. after Report Item 4.

MANAGEMENT REPORTS
1. Chief Financial Officer Report
Nancy Huang, Chief Financial Officer, provided three updates during her report. The first was regarding the status of hospital directed payments. Ms. Huang noted that, last week, CalOptima received approximately $97 million from the Department of Health Care Services (DHCS) for three hospital directed payment programs. The programs are: private hospital directed payment (PHDP), enhanced payment program (EPP), and the quality incentive program (QIP). Both PHDP and EPP payments are based on encounter data for dates of services (DOS) from July through December 2018, with some prior period adjustments. The QIP is for the full 2019-20 fiscal year. Ms. Huang noted that

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payments under these programs are scheduled to be released to participating hospitals before the end of September 2020.

Her second update was regarding CalOptima's development agreement extension request with the City of Orange. Ms. Huang noted that when CalOptima purchased the 505 City Parkway West building in Orange, the purchase included development rights to build a similar office tower with a parking structure. The current development agreement expires at the end of 2020. In December 2017, the CalOptima Board authorized staff to seek an extension. Staff has met with the City of Orange and has formally requested a six-year extension of the development agreement. Ms. Huang noted that staff plans to bring a request for approval of needed unbudgeted funds for this extension to the November Finance and Audit Committee (FAC) and then to the December Board for approval.

As noted at the top of the meeting, Chair Becerra reordered the agenda to hear Information Item 11. before Management Report 1.c.

INFORMATION ITEM

11. Intergovernmental Transfer Overview

Candice Gomez, Executive Director, Program Implementation, provided an Intergovernmental Transfer (IGT) overview. Ms. Gomez reviewed the background of IGTs, CalOptima's funding partners, and dollars received to date. The CalOptima Board has approved funding plans for IGT 1 through 9. For IGTs 1 through 7, the state allowed CalOptima to use the funds for enhanced benefits to existing Medi-Cal beneficiaries. However, beginning with IGT 8, the funds are considered part of the capitation revenue CalOptima receives and must be used for Medi-Cal covered services. Any expenditures of IGT funds that do not qualify as medical expenses are counted as part of CalOptima's administrative expenses by the state. Ms. Gomez also noted that COVID-19 had impacted some of the earlier IGTs, where grants were awarded to community-based organizations. Due to the pandemic, the scope of some of the grantees' projects has changed, and the Board has authorized time extensions to many of the grant awardees. This year, the Board authorized CalOptima's participation to pursue IGT 10 funding, which is estimated to total $66 million.

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Ms. Huang provided the third part of her CFO report, which addresses potential uses of IGT 10 funds, including partially offsetting the upcoming revenue shortfall from DHCS. She highlighted two main areas related to potential rate adjustments: 1) Medi-Cal Expansion Rates (MCE), and 2) Managed Medi-Cal Long Term Services and Support (MTLSS).

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for April 1, 2020 through June 30, 2020. The portfolio totaled approximately $1.7 billion as of June 30, 2020. Of this amount, $1.1 billion was in CalOptima's operating account and $585 million was included in CalOptima's Board-designated reserves.

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Meketa Investment Group Inc., CalOptima's Investment Advisor, completed an independent review of the monthly investment reports and reported that all investments were compliant with Government Code section 53600 et seq., and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

3. Approve the Minutes of the May 21, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the April 20, 2020 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

4. Consider Recommending that the Board of Directors Accept and Receive and File the Fiscal Year 2019-20 CalOptima Audited Financial Statements

Stacy Stelzriede of Moss-Adams, LLP, CalOptima's independent financial auditor, presented the draft audit of the consolidated financial statement for the fiscal year ending June 30, 2020. A detailed review of the areas of audit emphasis were presented, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. Ms. Stelzriede reported that Moss-Adams will be issuing an unmodified opinion on the financial Statements indicating that the FY 2019-20 financial statements fairly state the financial condition of CalOptima in all material respects.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors accept and receive and file the FY 2020 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adam, LLP. (Motion carried 2-0-0; Director Corwin absent)***

10. Consider Recommending that the Board of Directors' Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2021

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

Brigette Gibb, Executive Director, Human Resources, introduced the item.

Action: ***On motion of Director Corwin seconded and carried, the Committee recommended that Board of Directors: 1.) Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental and vision for CalOptima employees and eligible retirees (and their dependents), and basic life, accidental***

death and dismemberment, short-term disability and long-term disability insurance, and employee assistance program, and flexible spending account for Calendar Year 2021 in an amount not to exceed $23 million which includes the following proposed changes: a.) A decrease in employer contributions (based on the percentage of premium the employer pays from each plan), as a result of a 6.6% reduction in premium rates, reducing costs to CalOptima for CY 2021 in an amount of $1,444,451; b.) The addition of a new option for the Cigna Health Care (Cigna) HMO medical plan (Select Network) offered alongside the current full network Cigna HMO plan for active employees and eligible retirees with reduced premiums, which could result in an estimated cost savings of as much as $367,464 if employees select this plan over those with more expensive employee contribution rates; c.) An increase in employee contributions at each tier level for the current full network Cigna HMO plan to mirror the same employee contribution schedule as the Kaiser HMO medical plan; d.) A continuation of employer contributions for CY 2021 in an estimated amount of $182,500 to fund the Health Savings Accounts (HSA) monthly for employees currently enrolled in the Cigna High Deducible Health Plan; 2) Authorize the acceptance of the premium holiday in the amount of $125,000 received from Cigna Healthcare; and 3) Authorize the receipt and expenditures for CalOptima staff wellness programs from $25,000 in funding received from the Cigna Wellness/Health Improvement Fund for CY 2021. (Motion carried 2-0-0; Director Schoeffel absent)

5. Consider Recommending that the Board of Directors' Reappointment to the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors reappoint David Young to the Board of Directors' Investment Advisory Committee for a two-year term beginning October 1, 2020. (Motion carried 3-0-0)***

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

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors appoint the following two individuals to the Board's Investment Advisory Committee for two-year terms beginning October 1, 2020: 1.) Collen Clark; and 2.) David Hutchison. (Motion carried 3-0-0)***

7. Consider Recommending Board of Directors' Authorize COVID-19 Related Unbudgeted Expenditures

Ms. Huang noted that the title on the agenda should reflect that this is a ratification due to timing of the purchases and that this will be corrected on the October Board agenda.

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Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $137,802. (Motion carried 3-0-0)***

8. Consider Recommending Board of Directors' Authorization of Proposed Budget Allocation Changes in the CalOptima FY 2020-2021 Operating Budget

Ladan Khamseh, Chief Operating Officer, introduced the item.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors authorize the reallocation of the following budgeted funds from Medi-Cal: Other Operating Expenses to fund the Informatica Data Masking Software Maintenance license fee through June 30, 2021: 1) $67,950 from the Cloud Government/Storage Subscription; and 2) $67,950 from the Computer Equipment. (Motion carried 3-0-0)***

9. Consider Recommending Board of Directors' consider Authorizing the Ratification of Budget Reallocation changes in the CalOptima FY 2020-21 Capital Budget for Various Information Services Capital Projects

Staff noted that the agenda title incorrectly reflects that this item is a reallocation and should reflect that it is a reapportionment.

Ms. Huang introduced the item.

Action: ***On motion of Director Schoeffel seconded and carried, the Committee recommended that the Board of Directors authorize the ratification of reapportionment of budgeted funds among capital expense categories for various information services capital projects. (Motion carried 3-0-0)***

INFORMATION ITEMS

12. March 2020 Financial Summary

Ms. Huang briefly responded to Director Corwin's question regarding the operating deficit for the month of July 2020.

The following Information Items were accepted as presented:

13. CalOptima Information Security Update
14. Quarterly Operating and Capital Budget
15. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Whole-Child Model Financial Report
    c. Health Homes Financial Report
    d. Reinsurance Report
    d. Health Network Financial Report
    e. Contingency Contract Report

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Richard Sanchez, Interim Chief Executive Officer, suggested that Committee members receive an overview of the Office of Compliance from CalOptima's Compliance Officer, Silver Ho, at the next Finance and Audit Committee (FAC) meeting.

COMMITTEE MEMBER COMMENTS

Director Schoeffel welcomed members to the FAC.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 3:33 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 19, 2020

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MINUTES

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

August 13, 2020

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on August 13, 2020, at CalOptima, 505 City Parkway West, Orange, California.

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

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

Members Absent:

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

Chair Tolbert welcomed the new MAC members Melisa Nicholson and Steve Thronson to the Committee. The new members were appointed at the June 4, 2020 Board meeting and began their terms on July 1, 2020.

MINUTES

Approve the Minutes of the June 11, 2020 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Molnar, seconded and carried, the MAC approved the minutes as submitted. (13-0-0, member)***

PUBLIC COMMENT
There were no public comments.

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REPORTS

Consider Recommendation of Consumer Representative Seat

MAC received a letter of interest from Kate Polezhaev a current CalOptima Medi-Cal member. Ms. Polezhaev is a full-time student at California State University, Fullerton where she is studying for her master's degree in Public Policy. Ms. Polezhaev 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.

Action: ***On motion of Member Pimentel, seconded and carried, the Committee approved the recommendation of the Consumer Representative seat (Motion carried 13-0-0)***

Consider Recommendation of MAC Chair and Vice Chair

MAC received a letter of interest for the Chair position from Christine Tolbert current Chair and the Persons with Special Needs Representative. After no further nominations from the floor, Member Vega requested a motion to recommend Christine Tolbert as the MAC Chair for FY 2020-22.

Action: ***On motion of Member Mouton, seconded and carried, the Committee approved the recommendation of Christine Tolbert as the MAC Chair (Motion carried 13-0-1 Chair Tolbert abstained)***

MAC also received a letter of interest from current MAC member Pamela Pimentel Children Representative for the Vice Chair position. There were no further nominations from the floor, Member Vega asked for a motion to recommend Pamela Pimentel as the MAC Vice Chair for 2020-22.

Action: ***On motion of Member Tolbert, seconded and carried, the Committee approved the recommendation of Pamela Pimentel as the MAC Vice Chair (Motion carried 12-0-1; Vice Chair Pimentel abstained)***

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer (CEO), provided a verbal update on the Department of Health Care Services (DHCS) Medi-Cal expansion rate reductions which will be implemented on January 1, 2021. He noted that more information will be forthcoming from DHCS and that he would keep the MAC updated.

Chief Operating Officer (COO) Update

Ladan Khamseh, Chief Operating Officer, welcomed the new MAC members to the Committee and provided a verbal update on the annual Qualified Medicare Beneficiary (QMB) outreach program and noted that letters were sent out to members who have Part B Medicare but also qualify for Part A. Ms. Khamseh discussed how all Medi-Cal Managed Care Plans including CalOptima would

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need to apply for the Annual Health Network Certification by March 2021, which would become effective July 2021. Ms. Khamseh asked Michelle Laughlin, Executive Director, Network Operations to provide a brief report on CalOptima's plan for network certification.

Chief Medical Officer (CMO) Update

David Ramirez, M.D., Chief Medical Officer, discussed the COVID-19 numbers for Orange County. He noted that testing capabilities have increased in Orange County and new testing sites have opened throughout the County with a large site at the Anaheim Convention Center. Dr. Ramirez also provided an update on the Health Home Program Phase 2 which became effective July 1, 2020 and the Hospital Data Exchange Program. Dr. Ramirez updated the committee on the status of the virtual care or telehealth options that are available to CalOptima and its members. He also noted that over 200,000 members have used this option.

INFORMATION ITEMS

MAC Member Updates

Chair Tolbert announced that the Board at their August 6, 2020 meeting appointed Steve Thronson as the Orange County Healthcare Agency (OHCA) representative. She also announced that Diana Cruz-Toro had resigned her seat from the MAC due to her pending retirement from the Social Services Agency. Chair Tolbert thanked Ms. Cruz-Toro for her service on the MAC and noted that a special recruitment will be undertaken for a CalWORKS Representative. Chair Tolbert noted that the committee also continues to recruit for a Medi-Cal Beneficiaries Representative. Ms. Tolbert reminded the Members of the upcoming Joint Meeting scheduled for October 8, 2020 at 8:00 AM with the OneCare Connect Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee.

Homeless Health Initiative Update

David Ramirez, M.D., and Candice Gomez, Executive Director, Program Implementation presented on the Homeless Health Initiative. Ms. Gomez discussed the Homeless Health Initiative goals, Clinical Field Teams (CFT) pilot design, the CFT's structure, scheduled services at shelters, hotspots and the referral source role. Dr. Ramirez provided an overview of the roles that CalOptima, the Health Networks as well as CFT facts and figures that included the number of calls dispatched, number of patients treated and provided detailed numbers of on-call visit locations and referral sources.

Federal & State Legislative Update

TC Roady, Director, Regulatory Affairs, provided a verbal update on the FY 2020-21California State Budget which officially went into effect on June 29, 2020. Mr. Roady noted that due to COVID-19 impacts and the anticipated budget deficit and Medi-Cal enrollment growth, the CalAIM Program has been postponed. Mr. Roady also reviewed the Pharmacy Carve-Out which becomes effective date January 1, 2021.

Annual HEDIS Update

Irma Munoz, Project Manager Lead, Quality Analytics, gave a brief presentation on CalOptima's annual HEDIS results. Ms. Munoz reviewed DHCS regulatory reporting requirements for Managed

Care Plans called the Managed Care Accountability Set (MCAS) and the National Committee for Quality Assurance (NCQA) accreditation scores. Ms. Munoz noted that the medical records data collection had faced challenges due to COVID-19 and that CalOptima was successful in meeting all the DHCS minimum performance levels.

ADJOURNMENT

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: November 12, 2020

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MINUTES

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

September 10, 2020

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held virtually via GoTo Webinar on Thursday, September 10, 2020, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

PAC Chair Junie Lazo-Pearson, called the meeting to order at 8:04 a.m. and Vice Chair John Nishimoto, O.D., led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Amin Alpesh, M.D.; Anjan Batra, M.D.; Jennifer Birdsall, Ph.D; Tina Bloomer, MHNP; Donald Bruhns; Andrew Inglis, M.D.; Jena Jensen; Peter Korchin; Teri Miranti; Alexander Rossel; Loc Tran, PharmD.; Christy Ward

Members Absent: John Kelly, M.D.

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 Director; Candice Gomez, Executive Director, Program Implementation; Michelle Laughlin, Executive Director, Network Operations; Belinda Abeyta, Executive Director, Operations; TC Roady, Director Regulatory Affairs; Paul Jiang, Manager Quality Analytics; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant.

MINUTES

Approve the Minutes of the August 13, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee.

Action: ***On motion of Member Ward, seconded and carried, the Committee approved the minutes of the August 13, 2020 regular meeting. (Motion carried 14-0-0; Member Kelly absent)***

PUBLIC COMMENTS

There were no public comments.

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer (CEO), provided a brief update and told the committee that CalOptima's Board of Directors' had appointed a new Chair and Vice Chair. Supervisor Andrew Do was elected Chair and Isabel Becerra was elected Vice Chair. Mr. Sanchez also provided an update on the Department of Health Care Services (DHCS) Medi-Cal expansion rates.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, provided an update on the DHCS Pharmacy Portal, which will go into effect January 1, 2021. Dr. Ramirez notified the committee that the website and the portal is available for providers to register for the Medi-Cal Rx program including the training programs. He noted that members and providers will be sent 90, 60 and 30-day notices from DHCS and a 30-day notice from CalOptima. Dr. Ramirez also told the committee that the Long-Term Care at Home Program has been officially cancelled by DHCS.

Network Operations Update

Michelle Laughlin, Executive Director, Provider Network Operations, provide an update on the health network certification progress for DHCS.

INFORMATION ITEMS

Intergovernmental Transfer Funds (IGT) Update

Candice Gomez, Executive Director, Program Implementation, provided a update on Intergovernmental Transfer Funds (IGT). Ms. Gomez reminded the members that CalOptima's IGT 1-9 funds were available to provide enhanced benefits to existing CalOptima members and the funds must be used for CalOptima Medi-Cal covered services. She also discussed how IGT funds 5 and 7 had been impacted due to COVID-19. Ms. Gomez also reviewed the status of the IGT 10 funds which the CalOptima Board approved in February 2020.

Annual HEDIS Report

Paul Jiang, Manager, Quality Analytics, provided the Annual Health Effectiveness Data and Information Set (HEDIS) 2020 results.

Federal & State Legislative Update

TC Roady, Director, Regulatory Affairs, provided a brief verbal update on the Pharmacy Carve-Out which is slated to take effect January 1, 2021. Mr. Roady also discussed the Provider Relief Fund and the Federal and State Budget.

Member Advisory Committee (MAC) Update

Christine Tolbert, MAC Chair provided a brief update on the MAC initiatives for 2021 which included working more closely on items of interest with the PAC.

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PAC Member Updates

Chair Lazo-Pearson reminded the members that their compliance courses were due by November 6, 2020 and to reach out to Cheryl Simmons if they had any questions or problems.

ADJOURNMENT

Chair Lazo-Pearson announced that the next meeting was a joint meeting with the Member Advisory Committee, OneCare Connect Member Advisory Committee and the Whole-Child Model Family Advisory Committee and was scheduled for Thursday, October 8, 2020 at 8:00 a.m. and that more information would be sent closer to that date.

Hearing no further business, Chair Lazo-Pearson adjourned the meeting at 9:41 a.m.

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

Approved: November 12, 2020

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MINUTES

JOINT MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE, ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE, PROVIDER ADVISORY COMMITTEE AND WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE

October 8, 2020

A Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and Whole-Child Model Advisory Committee (WCM FAC) was held on Thursday, October 8, 2020 via GoTo Webinar at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

MAC Chair Tolbert called the meeting to order at 8:05 a.m., and WCM FAC Vice Chair Deeley led the Pledge of Allegiance.

ESTABLISH QUORUM

Member Advisory Committee

Members Present: Christine Tolbert, Chair; Maura Byron; Sandy Finestone; Connie Gonzalez; Hai Hoang; Sally Molnar; Patty Mouton; Melisa Nicholson; Kate Polezhaev; Sr. Mary Terese Sweeney; Steve Thronson

Members Absent: Pamela Pimentel, Vice Chair; Mallory Vega

OneCare Connect Member Advisory Committee

Members Present: Patty Mouton, Chair; Keiko Gamez, Vice Chair; Meredith Chillemi; Josefina Diaz; Eleni Hailemariam, M.D. (non-voting); Sandy Finestone; Sara Lee; Mario Parada; Donald Stukes

Members Absent: Jyothi Atluri (non-voting); Gio Corzo; Erin Ulibarri (non-voting)

Provider Advisory Committee

Members Present: Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Alpesh Amin, M.D.; Anjan Batra, M.D.; Jennifer Birdsall, Tina Bloomer; Donald Bruhns, Dr. Inglis, Jena Jensen; John Kelly, M.D.; Teri Miranti; Alex Rossel; Loc Tran, Pharm.D.

Members Absent: Peter Korchin; Christy Ward

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Whole-Child Model Family Advisory Committee

Members Present: Brenda Deeley, Vice Chair; Maura Byron; Sandra Cortez-Schultz; Jacque Knudsen; Monica Maier; Malissa Watson;

Members Absent: Cathleen Collins, Kathleen Lear, Kristen Rogers
WCM FAC did not achieve a quorum.

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; Belinda Abeyta, Executive Director, Operations; Candice Gomez, Executive Director, Program Implementation; Betsy Ha, Executive Director, Quality and Population Health Management; Tracy Hitzeman, Executive Director Clinical Operations; Michelle Laughlin, Executive Director, Network Operations; Thanh-Tam Nguyen, M.D., Medical Director, Medical Management; Albert Cardenas, Director, Customer Service; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant, Customer Service

PUBLIC COMMENT

There were no requests for public comment.

CHIEF EXECUTIVE OFFICER WELCOME

Richard Sanchez, Interim Chief Executive Officer, welcomed members from the four Board Advisory Committees.

INFORMATION ITEMS

25th Anniversary Presentation

Ladan Khamseh, Chief Operating Officer, provided a brief review of CalOptima's first 25 years. Ms. Khamseh thanked the Chairs, Vice Chairs and members of the advisory committees as well as the providers who have served since CalOptima's inception in 1995. Ms. Khamseh suggested that the members review the full presentation at their leisure.

WCM FAC Vice Chair Deeley reordered the agenda to hear V.C Medi-Cal Rx ahead of the Be Well OC presentation to allow time to address technical issues related to that presentation.

Medi-Cal Rx

OCC MAC Vice Chair Keiko Gamez introduced Emily Fonda, M.D., Deputy Chief Medical Officer. Dr. Fonda provided an overview of the Department of Health Care Services' (DHCS)

plan to transition of the Medi-Cal Pharmacy benefit from the Managed Care Plans (MCPs) (including CalOptima) to Medi-Cal fee-for-service (FFS) program effective January 1, 2021. Dr. Fonda noted that there would be no change to OneCare (OC) and OneCare Connect (OCC) and PACE members as they will continue receiving medications through CalOptima's Pharmacy Benefit Manager (PBM), MedImpact. Committee members continued to express concerns about the transition and about the importance of ensuring that members continue to have access to the medications they need.

Be Well OC

WCM FAC Vice Chair Deeley introduced Marshall Moncrief, Chief Executive Officer of Mind-OC. Mr. Moncrief provided an overview of the Be Well OC program, noting that it is intended to facilitate coordination of the delivery of behavioral health healthcare services.

Myopia Control

PAC Vice Chair Nishimoto introduced Erin Rueff, O.D., who provided a presentation on Myopia or "nearsightedness" in children. Dr. Rueff noted that half of the world's population are projected to be affected by myopia by 2050 and discussed how extensive optometric and ophthalmological research has been able to slow the progression of myopia by using topical eye drops and specially designed contact lenses.

COMMITTEE MEMBER UPDATES

MAC Chair Tolbert welcomed Kate Polezhaev to the MAC as the new Consumer Representative and asked the members to continue to help with the recruitment of a Medi-Cal Beneficiaries Representative. Chair Tolbert announced MAC would hold a special meeting on November 12, 2020 at 2:30 P.M.

OCC MAC Vice Chair Gamez welcomed Meredith Chillemi as the new Long-Term Care Representative on the OCC MAC and announced the next OCC MAC regular meeting is scheduled for October 22, 2020 at 3:00 P.M.

PAC Chair Dr. Lazo-Pearson announced that PAC would hold its regular meeting on November 12, 2020 and that there would be a Special Joint Meeting of all Board Advisory Committees on December 10, 2020 at 8:00 A.M. She also reminded all committee members that compliance training needs to be completed by November 6, 2020.

WCM FAC Vice Chair Deeley announced WCM FAC would hold its regular meeting on October 27, 2020 at 9:30 A.M.

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ADJOURNMENT

There being no further business before the Committees, WCM FAC Vice Chair Deeley adjourned the meeting at 10:30 a.m.

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

Approved by OCC MAC: October 22, 2020
Approved by MAC: November 12, 2020
Approved by PAC: November 12, 2020

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Belinda Abeyta, Executive Director, Operations, (657) 235-6755

Recommended Action

The CalOptima Member Advisory Committee recommends:

1. Appointment of the following individual to serve the reminder of a two-year term on the Member Advisory Committee, effective upon Board approval:
    a. Jacqueline Gonzalez as the CalWORKs Representative to serve the remainder of a two-year term ending June 30, 2021.

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, with the exception of the two standing seats: the Orange County Health Care Agency representative and the Orange County Social Services Agency representative, which have an unlimited term. The CalOptima Board is responsible for the appointment of all MAC members.

Discussion

CalOptima conducted outreach from August through October to recruit potential candidates. The recruitment included the following notification methods: recruitment material on CalOptima's website, sent to community-based organizations (CBOs); targeted community outreach to agencies and CBOs that serve the open position. Staff also presented information at the MAC meetings about the open committee seat and noted the vacancy through the CalOptima Community Relations newsletters to enhance recruitment efforts. CalOptima received one applicant and submitted it to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on October 21, 2020, subcommittee members evaluated the applicant. The subcommittee included members Melisa Nicholson, Steve Thronson and Christine Tolbert, who recommended the candidate and forwarded the proposed candidate to the MAC for consideration.

At the November 12, 2020, special MAC meeting, MAC voted to accept the recommended candidate as proposed by the Nominations Ad Hoc and requested that the proposed candidate be forwarded to the CalOptima Board of Directors for consideration.

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The recommended candidate for CalWORKs Representative seat is:

CalWORKs Representative Candidate
Jacqueline Gonzalez*

Jacqueline Gonzalez is a Social Services Supervisor II with the Family Self Sufficiency division of the Orange County Social Services Agency. With more than 15 years of experience at the county level, Jacqueline has worked with CalOptima members as an eligibility worker and eligibility supervisor to assist and guide CalWORKs clients.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy AA.1219a, the MAC established a Nominations Ad Hoc Committee to review potential candidates for vacancies on the Committee. The MAC met to discuss the Ad Hoc's recommended candidate and concurred with the subcommittee's recommendation. 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 — *11/24/2020*
Authorized Signature — **Date**

***Indicates MAC recommendation**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Action

Recommend approval of proposed changes to CalOptima Policy GA.3400: Annual Investments.

Background

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

At the December 5, 2019, meeting, the Board approved changes to CalOptima Policy GA.3400: Annual Investments for Calendar Year 2020. At that time, staff, in conjunction with Meketa Investment Group, Inc., and CalOptima's investment managers, Payden & Rygel, MetLife and Wells Capital Management, recommended revisions to the AIP to:

- Clarify the primary benchmark for each investment portfolio for short term investments, and timeframes and responsible parties to review said benchmarks;
- Implement changes to conform to California Government Code (CGC) Local Agency Investment Guidelines;
- Clarify Investment Manager reporting requirement if diversification limits are exceeded;
- Clarify entities to receive listing or notification of prohibited investments from the Board; and
- Update glossary terms.

At the June 4, 2020, meeting, the Board approved changes to CalOptima Policy GA.3400: Annual Investments clarify counterparty diversification limits. The policy was revised to implement a 5% portfolio maximum limitation per credit counterparty and by instrument type to include all permitted investments except for U.S. Government or Agency securities effective June 1, 2020.

Discussion

Payden & Rygel, MetLife, and Wells Capital Management, CalOptima's investment managers, and Meketa Investment Group, Inc., CalOptima's investment adviser submitted proposed revisions to CalOptima Policy GA.3400: Annual Investments for Calendar Year (CY) 2021. Staff has reviewed the proposed revisions and recommends the following changes upon Board approval:

- Changes to conform to language in the California Government Code (CGC) Local Agency Investment Guidelines:

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- Section III.D.2.c.i.: State and California Local Agency Obligations, allow short term investments with rating of F1 or better by Fitch Ratings Service; and

- Section III.D.2.e.i.a) and b): Commercial Paper (CP), modify the criteria for allowable investments, to specify CP rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO).

- Section III.E.5.a.: Diversification Guidelines, establish a distinction between separate securitized trusts for the maximum issuer limits at the deal level since each is generally a unique "issuer."

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

At its October 19, 2020, meeting, the IAC recommended that the Finance and Audit Committee recommend that the Board approve the proposed changes to CalOptima Policy GA.3400.

Fiscal Impact
There is no immediate fiscal impact.

Rationale for Recommendation
The proposed changes to CalOptima Policy GA.3400: Annual Investments reflect the recommendations of CalOptima's investment managers, Payden & Rygel, MetLife, and Wells Capital Management and concurrence by CalOptima's investment adviser, Meketa Investment Group, Inc. These recommended changes continue to support CalOptima's goals to maintain safety of principal and achieve a market rate of return while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the California Government Code affecting local agencies noted for the CY 2021.

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

Attachment
1. Policy GA.3400: Annual Investments (redline and clean versions)

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Administrative
Section:	Finance
CEO Approval:	
Effective Date:	01/01/2018
Revised Date:	01/01/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

3. Liquidity: Liquidity is the second most important objective of CalOptima. It is important that each portfolio contain investments for which there is a secondary market and which offer the

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flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Treasurer's objectives.

    a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

        i. These performance Benchmarks shall be reviewed monthly by CalOptima staff, and quarterly by CalOptima's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

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

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

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

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

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

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

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

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

III. PROCEDURE

A. Delegation of Authority

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

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

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

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

B. CalOptima Treasurer Responsibilities

1. The Treasurer shall be responsible for:

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

b. The oversight of CalOptima's Investment Portfolio;

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

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

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

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

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

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

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

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

C. Investment Advisory Committee

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

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

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

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

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

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

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

D. Permitted Investments

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

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

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

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

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

2. Permitted investments shall include:

a. U.S. Treasuries

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

ii. U.S. Government securities include:

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

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

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

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

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

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

iv. Maximum Term:

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

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

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

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

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

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

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

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

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

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

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

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

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

d. Banker's Acceptances

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

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

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days

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

e. Commercial Paper (CP)

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

a) CP of "prime" quality ~~of the highest ranking or of the highest letter and number rating as provided for~~, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO);

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by an NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by an NRSRO; and

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

ii. Maximum Term:

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

f. Negotiable Certificates of Deposit

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

ii. Maximum Term:

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

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

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

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

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

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

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year

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

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by an NRSRO and:

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

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

ii. Maximum Term:

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

i. Money Market Funds

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

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

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

j. Joint Powers Authority Pool

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

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

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

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

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

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

k. Mortgage or Asset-backed Securities

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

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

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

a) Are rated AA or better- or equivalent.

iv. Maximum Term:

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

l. Variable and Floating Rate Securities

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

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

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

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

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

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

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

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

iii. Maximum Term:

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

m. Supranational Obligations

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

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

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

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

n. Pooled Investments

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

E. Diversification Guidelines

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

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

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

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

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

a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

b. Any one (1) repurchase agreement counterparty name:

If maturity/term is $\leqslant$ 7 days: 50%
If maturity/term is > 7 days: 25%

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

   a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level~~-~~ with each securitized trust being considered a unique "issuer."

   b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

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

   a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

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

      i. The amount in relation to the total portfolio concentration;

      ii. Market and security specific conditions contributing to a breach of this Policy; and

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

F. Maximum Stated Term

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

G. Rating Downgrades

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

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

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

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

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

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

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

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

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

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

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §6509.7
B. California Government Code, §53600 et seq.
C. California Government Code, §53601(h), (k), (q)
D. California Government Code, §53635 et seq.
E. California Government Code, §53646, Subdivision (a) and Subdivision (b)
F. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

A. None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima's regulatory compliance requirements; or b. Currently defined as CalOptima's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.

Term	Definition
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Board of Directors with oversight responsibilities for all financial matters of CalOptima including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding CalOptima's Investment Policies, Procedures and Practices.

Term	Definition
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.

Term	Definition
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima's asset managers provide CalOptima with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima. Each asset manager uses a variety of market sources to determine individual Valuations.

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Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Administrative
Section:	Finance
CEO Approval:	
Effective Date:	01/01/2018
Revised Date:	01/01/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

3. Liquidity: Liquidity is the second most important objective of CalOptima. It is important that each portfolio contain investments for which there is a secondary market and which offer the

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flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Treasurer's objectives.

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

      i. These performance Benchmarks shall be reviewed monthly by CalOptima staff, and quarterly by CalOptima's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

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

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

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

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

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

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

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

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

III. PROCEDURE

A. Delegation of Authority

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

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

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

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

B. CalOptima Treasurer Responsibilities

1. The Treasurer shall be responsible for:

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

b. The oversight of CalOptima's Investment Portfolio;

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

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

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

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

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

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

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

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

C. Investment Advisory Committee

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

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

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

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

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

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

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

D. Permitted Investments

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

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

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

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

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

2. Permitted investments shall include:

a. U.S. Treasuries

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

ii. U.S. Government securities include:

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

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

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

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

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

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

iv. Maximum Term:

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

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

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

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

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

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

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

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

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

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

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

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

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

d. Banker's Acceptances

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

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

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days

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

e. Commercial Paper (CP)

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

a) CP of "prime" quality, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO);

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by an NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by an NRSRO; and

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

ii. Maximum Term:

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

f. Negotiable Certificates of Deposit

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

ii. Maximum Term:

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

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

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

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

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

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

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year

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

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by an NRSRO and:

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

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

ii. Maximum Term:

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

i. Money Market Funds

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

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

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

j. Joint Powers Authority Pool

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

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

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

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

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

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

k. Mortgage or Asset-backed Securities

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

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

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

a) Are rated AA or better or equivalent.

iv. Maximum Term:

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

l. Variable and Floating Rate Securities

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

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

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

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

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

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

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

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

iii. Maximum Term:

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

m. Supranational Obligations

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

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

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

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

n. Pooled Investments

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

E. Diversification Guidelines

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

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

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

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

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

a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

b. Any one (1) repurchase agreement counterparty name:

If maturity/term is $\leqslant$ 7 days: 50%
If maturity/term is > 7 days: 25%

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

   a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level with each securitized trust being considered a unique "issuer."

   b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

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

   a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

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

      i. The amount in relation to the total portfolio concentration;

      ii. Market and security specific conditions contributing to a breach of this Policy; and

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

F. Maximum Stated Term

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

G. Rating Downgrades

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

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

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

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

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

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

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

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

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

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

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §6509.7
B. California Government Code, §53600 et seq.
C. California Government Code, §53601(h), (k), (q)
D. California Government Code, §53635 et seq.
E. California Government Code, §53646, Subdivision (a) and Subdivision (b)
F. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

A. None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima's regulatory compliance requirements; or b. Currently defined as CalOptima's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.

Term	Definition
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Board of Directors with oversight responsibilities for all financial matters of CalOptima including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding CalOptima's Investment Policies, Procedures and Practices.

Term	Definition
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.

Term	Definition
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima's asset managers provide CalOptima with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima. Each asset manager uses a variety of market sources to determine individual Valuations.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

6. Consider Authorizing an Amendment to the Amended and Restated Development Agreement with the City of Orange to Extend CalOptima's Development Rights

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Amended and Restated Development Agreement with the City of Orange to extend its term for up to six (6) additional years, through October 28, 2026, contingent upon approval of the Orange City Council; and
2. Authorize unbudgeted expenditures in an amount up to $105,000 from existing reserves for fees associated with the amendment through June 30, 2021.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten (10) stories and 200,000 square feet of office space, and a parking structure of up to five (5) levels and 1,528 parking spaces. The office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the 505 City Parkway West building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the Board authorized execution of an amended and restated Development Agreement with the City of Orange to extend CalOptima's development rights for up to six (6) additional years, until October 28, 2020. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The CalOptima Board agreed to pay a required $200,000 public benefit fee in periodic payments to the City of Orange in exchange for the extension.

At its August 4, 2016 and December 1, 2016, meetings, the CalOptima Board authorized contracts with real estate consultant, Newport Real Estate Services, Inc., to evaluate options for CalOptima's current development rights and to create a site plan. Newport Real Estate Services completed the evaluation and presented the requested information to the CalOptima Finance and Audit Committee (FAC) on February 16, 2017. The FAC recommended the Board issue a Property and Associated Development Rights Request for Information (RFI) to gauge potential interest and options available. The Board approved the issuance of an RFI at its March 2, 2017, meeting.

The RFI response period closed on April 21, 2017, with only one response received. The limited response and staff's informal discussions with industry representatives during the RFI process primarily reflected limited interest in commercial office space development at that time.

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At its December 7, 2017, meeting, the Board authorized contacting the City of Orange to explore extension of the existing Development Agreement for as long as possible, and to broaden the rights from commercial/office to include urban mixed use, including transitional housing.

In 2018, CalOptima staff contacted the City of Orange to informally discuss the extension of the Development Agreement as well as the possibility of expanding its scope. During these discussions, the City expressed openness to extending the Development Agreement as well as considering expanding the scope to include "urban mixed use." However, the City expressed concern about the possibility of including transitional housing as the City already has several homeless housing arrangements in various, locations consistent with the City's General Plan, and noted that the 605 Project Site was not an ideal site for any type of transitional or permanent supportive housing given the proximity of commercial and retail elements nearby.

Discussion

On June 24, 2020, staff sent a request to amend the terms of the Development Agreement with the City of Orange. The amendment would extend CalOptima's development rights, under the current terms, for up to six (6) additional years, until October 28, 2026.

Under the proposed amendment, CalOptima will pay additional public benefit fees to the City of Orange. The total cost of the fees is up to $300,000, divided into installment payments over the term of the extension. With each payment of $100,000, the Development Agreement will remain in effect for an additional two-year period. Specifically, CalOptima will make the payments in three (3) installments:

- $100,000 within forty-five (45) days of mutual execution of the amendment;
- $100,000 no later than fifteen (15) days prior to the expiration of the First Extended Term; and
- $100,000 no later than fifteen (15) days prior to the expiration of the Second Extended Term.

This payment structure allows development flexibility to CalOptima to further determine its office space needs. In addition to the public benefit fees, CalOptima will pay administrative costs associated with the preparation and processing of the Development Agreement in an amount up to $5,000.

The Amendment to the Amended and Restated Development Agreement was approved by the City of Orange Planning Commission on October 19, 2020, and will be considered at a future Orange City Council meeting.

Fiscal Impact

The recommended action is an unbudgeted item. An allocation of up to $105,000 from existing reserves will fund this action through June 30, 2021. Upon Board approval, Management will include the remaining allocation of up to $200,000 for the extended terms in future operating budgets.

Rationale for Recommendation

The Development Agreement with the City of Orange provides CalOptima the opportunity to provide for future space needs in the event CalOptima requires additional office space. At the same time, the

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development rights are a valuable asset that can be severed from the existing parcel if CalOptima finds that CalOptima's construction of a separate office building and parking structure is not practical, feasible, or otherwise in the best interest of the organization.

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

Attachments
1. Entities Covered by this Recommended Action
2. Draft First Amendment to Amended and Restated Development Agreement
3. Ordinance No. xx-20: An Ordinance of the City Council of the City of Orange Approving a First Amendment to Amended and Restated Development Agreement
4. CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
5. CalOptima Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
6. NRES PowerPoint Presentation dated February 16, 2017: Long-Range Strategic Real Estate Plan –Excess Real Estate Development or Disposition Update
7. CalOptima Board Action dated December 7, 2017, Consider Actions Related to CalOptima's Agreement with the City of Orange

/s/ Richard Sanchez — *11/24/2020*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
City of Orange	300 E. Chapman Avenue	Orange	CA	92866

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 E. Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

FIRST AMENDMENT TO AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of _____, 2020

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

FIRST AMENDMENT TO
AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This First Amendment ("First Amendment") to the Amended and Restated Development Agreement ("Agreement") is made in Orange County, California as of ________, 2020, by and between the CITY OF ORANGE, a municipal corporation ("City"), and the ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("Developer"). City and Developer shall be referred to collectively as the "Parties."

RECITALS

This First Amendment is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

A. City and Developer entered into an Amended and Restated Development Agreement effective December 10, 2014 (the "Agreement").

B. The Agreement was set to expire on October 28, 2020.

C. The Parties wish to amend the Agreement and **Exhibit "D"** to provide for an extension of its term for up to six (6) additional years on the terms and conditions contained herein.

D. Pursuant to Government Code section 65867.5 and Orange Municipal Code section 17.44.100, the City Council finds that: (i) this Amendment and any Future Approvals of the Project is consistent with the objectives, policies, general land uses, and programs specified in the City's General Plan and any applicable specific plan or redevelopment plans; (ii) this Amendment is compatible with the uses authorized in the district or planning area in which the real property will be located; (iii) this Amendment is in conformity with the public necessity, public convenience, general welfare, and good land use practices; (iv) this Amendment is in the best interest of and not in detriment to the public health, safety and general welfare of the residents in the City and the surrounding region; (v) this Amendment will not adversely affect the orderly development of property in the City; and (vi) this Amendment is being entered into pursuant to and in compliance with the requirements of Government Code section 65867.

NOW THEREFORE, the Parties agree as follows:

1. Section 12 of the Agreement, "Term of Agreement," shall be amended in its entirety to read as follows:

> 12. **Revised Term of Agreement**. This First Amendment shall become operative and shall commence upon the date the ordinance approving this First Amendment, becomes effective. Subject to payment by Developer of the applicable Public Benefit Fees in the amounts and at the times identified in **First Amended Exhibit "D,"** attached hereto, this Agreement shall remain in effect for a period of up to twelve (12) years from the Original Termination Date unless this Agreement is terminated, modified

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or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth in **First Amended Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified in **First Amended Exhibit "D"**.

(a) **First Payment of Public Benefit Fees.** Within forty-five (45) days of mutual execution of this First Amendment by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee as identified in **First Amended Exhibit "D."** Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) additional years, such two (2) year period being the **"First Extended Term."**

(b) **Second Payment of Public Benefit Fees.** If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the First Extended Term, then Developer shall pay to the City the Second Public Benefit Fee as identified in **First Amended Exhibit "D"** no later than the time set forth in **First Amended Exhibit "D."** Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for a period of two (2) additional years from the expiration of the First Extended Term, such two (2) year period being the **"Second Extended Term."**

(c) **Third Payment of Public Benefit Fees.** If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Second Extended Term, then Developer shall pay to the City the Third Public Benefit Fee as identified in **First Amended Exhibit "D"** no later than the time set forth in **First Amended Exhibit "D."** Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for a period of two (2) additional years from the expiration of the Second Extended Term, such two (2) year period being the **"Third Extended Term."**

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the terms hereof or arising from the duties of the Parties as prescribed in this Agreement.

2. Exhibit "D" of the Agreement shall be replaced in its entirety with the attached **First Amended Exhibit "D,"** which is incorporated herein.

3. This First Amendment amends, as set forth herein, the Agreement and, except as specifically amended hereby, the Agreement shall remain in full force and effect. To the extent that there is any conflict or inconsistency between the terms and provisions of this First

Amendment and the terms and provisions of the Agreement, the terms and provisions of this First Amendment shall control and govern the rights and obligations of the parties.

4. This First Amendment shall become operative upon the date the ordinance approving this First Amendment becomes effective.

[Remainder of page intentionally left blank; signatures on next page]

"CITY"

CITY OF ORANGE, a municipal corporation

By: _____
Mark A. Murphy, Mayor

ATTEST:

_____
Pamela Coleman, City Clerk

APPROVED AS TO FORM:

_____
Mary E. Binning
Senior Assistant City Attorney

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima

By: _____
Print name:_____
Title:_____

ACKNOWLEDGMENT

State of California
County of Orange

On _____ before me, _____, a Notary Public, personally appeared _____
_____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

(Seal)

ACKNOWLEDGMENT

State of California
County of Orange

On _____ before me, _____, a Notary Public, personally appeared _____
_____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

(Seal)

FIRST AMENDED EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section 12 "**Revised Term of the Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of the First Amendment by Developer and the City, Developer shall pay to the City the sum of $100,000 (the "**First Public Benefit Fee**"). Such payment will initiate the First Extended Term.

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Extended Term, then Developer shall pay to the City the sum of $100,000 (the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Extended Term. Such payment will initiate the Second Extended Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Second Extended Term, then Developer shall pay to the City the sum of $100,000 (the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Second Extended Term. Such payment will initiate the Third Extended Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

ORDINANCE NO. xx-20

AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF ORANGE APPROVING A FIRST AMENDMENT TO AMENDED AND RESTATED DEVELOPMENT AGREEMENT (AGR. NO. 4545.OC) BY AND BETWEEN THE CITY OF ORANGE AND ORANGE COUNTY HEALTH AUTHORITY D.B.A. CALOPTIMA FOR A DEVELOPMENT PROJECT ON THE "605 BUILDING SITE," LOCATED ON THE SOUTHEAST CORNER OF LEWIS STREET AND CITY PARKWAY WEST (605 CITY PARKWAY WEST)

WHEREAS, Section 65864 et seq. of the California Government Code authorizes cities to enter into a Development Agreement with any person having a legal or equitable interest in real property for the development of such property; and

WHEREAS, the City Council ("City Council") of the City of Orange ("City") has adopted Chapter 17.44 of the Orange Municipal Code ("OMC"), which establishes procedures for the processing and approval of Development Agreements; and

WHEREAS, by the adoption of Ordinance No. 19-04 on September 28, 2004, the City Council approved that certain Development Agreement by and between the City and CA-The City Limited Partnership, a Delaware limited partnership ("Original Developer"), relating to certain real property located in the City of Orange commonly referred to as the "City Plaza Two Site" and the "605 Building Site", which are more particularly described in the Development Agreement, recorded in the Official Records of the County of Orange ("Official Records") on January 6, 2005 as Instrument No. 2005000013339 ("Original Development Agreement"); and

WHEREAS, by the adoption of Ordinance No. 20-05 on January 10, 2006, the City Council of the City of Orange approved a First Amendment to the Original Development Agreement, which was recorded in the Official Records on January 24, 2006 as Instrument No. 2006000051175; and

WHEREAS, by the adoption of Ordinance No. 13-06 on September 12, 2006, the City Council approved a Second Amendment to the Original Development, which was recorded in the Official Records on October 17, 2006 as Instrument No. 2006000698031; and

WHEREAS, the Orange County Health Authority, doing business as CalOptima, is the assignee and successor-in-interest to the Original Development Agreement as it relates to the 605 Building Site only and the City Council memorialized that assignment by the adoption of Ordinance No. 06-14 on November 25, 2014, approving that certain Amended and Restated Development Agreement by and between the City of Orange and CalOptima, the original of which was recorded in the Official Records on December 11, 2014, as Instrument No. 2014000535189, City Agreement No. 4545.OC ("Amended and Restated Development Agreement"); and

WHEREAS, CalOptima has made an application to the City to enter into a First Amendment to the Amended and Restated Development Agreement to extend the Term of the Amended and Restated Agreement by six years; and

WHEREAS, Section 65868 of the California Government Code and OMC Section 17.44.160 permit the amendment of the Amended and Restated Agreement by mutual consent of the parties to the agreement, pursuant to the same procedure as for entering into a Development Agreement, namely that a noticed public hearing must be held by both the Planning Commission and the City Council and such amendment, if approved, must be approved by ordinance; and

WHEREAS, an environmental review was conducted by the City, as the "lead agency", under the California Environmental Quality Act ("CEQA") to evaluate the projects described in the Original Development Agreement, together with development projects for two other separate development sites owned by the Original Developer or its affiliates. As a result of the environmental review, Final Environmental Impact Report 1612-01 ("Final ElR") was prepared and certified by the City Council in accordance with CEQA on October 9, 2001; and

WHEREAS, further environmental review was conducted by the City at the time the Original Developer applied for the Original Development Agreement. In compliance with CEQA and the State CEQA Guidelines, the City prepared an Addendum to the Final ElR because "none of the conditions described in Section 15162 (of the State CEQA Guidelines) calling for the preparation of a subsequent ElR or negative declaration had occurred" in connection with the Developer's application for the Development Agreement; and

WHEREAS, due to the nature of the proposed First Amendment to the Amended and Restated Development Agreement, this City Council again finds and determines that "none of the conditions described in Section 15162 (of the State CEQA Guidelines) calling for the preparation of a subsequent ElR or negative declaration have occurred"' in connection with the proposed First Amendment to the Amended and Restated Development Agreement; and

WHEREAS, in accordance with State and local law, on October 19, 2020, the Planning Commission of the City of Orange conducted a duly noticed public hearing on the proposed First Amendment to the Amended and Restated Development Agreement in substantially the form attached to this Ordinance as Exhibit “A,” considered information presented by City staff and public testimony regarding the proposed First Amendment to the Amended and Restated Development Agreement, and, by a vote of not less than a majority of its total membership, recommended that the City Council approve the First Amendment to the Amended and Restated Development Agreement; and

WHEREAS, in accordance with State and local law, on November 10, 2020, the City Council conducted a duly noticed public hearing on the proposed First Amendment to the Amended and Restated Development Agreement, reviewed and considered proposed First Amendment to the Amended and Restated Development Agreement, and information presented by City staff and heard public testimony regarding the proposed First Amendment to the Amended and Restated Development Agreement.

NOW, THEREFORE, THE CITY COUNCIL OF THE CITY OF ORANGE DOES ORDAIN AS FOLLOWS:

SECTION I:

The City Council finds that a public hearing has been held before this City Council pursuant to the procedures described in Chapter 17.44 of the Orange Municipal Code. At the hearing, the City Council has considered testimony presented by the public and the Planning Commission's recommendation to approve the First Amendment to the Amended and Restated Development Agreement between the City of Orange and CalOptima.

SECTION II:

The City Council hereby finds that the First Amendment to the Amended and Restated Development Agreement between the City of Orange and CalOptima:

A. Is consistent with the objectives, policies, general land uses, and programs specified in the General Plan; and

B. Is compatible with the uses authorized in, and the regulations prescribed for, the zoning district in which the 605 Building Site is and will be located, and is consistent with the City's Zoning Code; and

C. Is in conformity with and will promote public necessity, public convenience, general welfare, and good land use practices; and

D. Will be beneficial to the health, safety, and general welfare; and

E. Will not adversely affect the orderly development of property or the preservation of property values; and

F. Will promote and encourage the development of the proposed project by providing a greater degree of requisite certainty.

SECTION III:

The City Council approves and incorporates by reference the First Amendment to the Amended and Restated Development Agreement attached hereto as Exhibit "A." Within ten (10) days after this Ordinance takes effect and provided that CalOptima has first executed the First Amendment to the Amended and Restated Development Agreement in recordable form and delivered same to the City, the Mayor shall execute the First Amendment to the Amended and Restated Development Agreement in recordable form.

SECTION IV:

Within ten (10) days after the execution of the First Amendment to the Amended and Restated Development Agreement by all parties, the City Clerk is authorized and directed to record the First Amendment to the Amended and Restated Development Agreement in the Official Records.

SECTION V:

The City Clerk is hereby directed to certify the adoption of this Ordinance and cause a summary of the same to be published as required by law. This Ordinance shall take effect thirty (30) days from the date of adoption.

ADOPTED this ____ day of _____, 2020.

_____
Mark A. Murphy, Mayor, City of Orange

ATTEST:

_____
Pamela Coleman, City Clerk, City of Orange

STATE OF CALIFORNIA)
COUNTY OF ORANGE)
CITY OF ORANGE)

I, PAMELA COLEMAN, City Clerk of the City of Orange, California, do hereby certify that the foregoing Ordinance was introduced at the regular meeting of the City Council held on the ___ day of _____, 2020, and thereafter at the regular meeting of said City Council duly held on the ___ day of _____, 2020 was duly passed and adopted by the following vote, to wit:

AYES: COUNCILMEMBERS:
NOES: COUNCILMEMBERS:
ABSENT: COUNCILMEMBERS:
ABSTAIN: COUNCILMEMBERS:

_____
Pamela Coleman, City Clerk, City of Orange

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

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Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

* $ R 0 0 0 7 1 5 5 2 6 5 $ *

2014000535189 9:23 am 12/11/14
93 413 A17 35
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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

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Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

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(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

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(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

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(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

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otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

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Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

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DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

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ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

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EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

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widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

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ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

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EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

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Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

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Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
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Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

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(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

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(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

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(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

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otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

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Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

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DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

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ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

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EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

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widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

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ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

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EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

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LONG-RANGE STRATEGIC REAL ESTATE PLAN – EXCESS REAL ESTATE: DEVELOPMENT OR DISPOSITION - UPDATE

FINANCE AND AUDIT COMMITTEE MEETING

FEBRUARY 16, 2017

GLEN ALLEN, PRESIDENT

NEWPORT REAL ESTATE SERVICES, INC.

NEWPORT
Real Estate Services, Inc.®

Purpose of Presentation

- CalOptima Staffing Needs
- Review Site Plan
- Review Development Rights Options: Pros/Cons
- Review Development Rights Timeline
- CalOptima Development vs. 3rd Party Disposition

NEWPORT
Real Estate Services, Inc.®

Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

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Real Estate Services, Inc.®

Needs Assessment - Assumptions

- Optimized Telecommuting
- Assumes Projected Programs
  - Cal-MediConnect
  - Medi-Cal
  - OneCare
  - PCC Program
  - ACA Related and Demographic-Trend Member Growth
- Recapture of all 505 Space
- 1 person/181 s.f. space allocation

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Real Estate Services, Inc.®

Current Space Projection

505 Building Available Seats	
On Site	749
Filled Seats	46
Sub-Total	**795**
Teleworker/Community	318
Total	**1,114**
Total Space Available	**1,025**
Filled Seats and Temp Help	(795)
Total Vacant Spaces	**257**
Pending Requests to Fill	(142)
Expected Employee Count for New Programs	(26)
Net Space Surplus (Shortfall)	**89**
10th Floor Space	85
Total Surplus (Shortfall)	**174**

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Real Estate Services, Inc.®

Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

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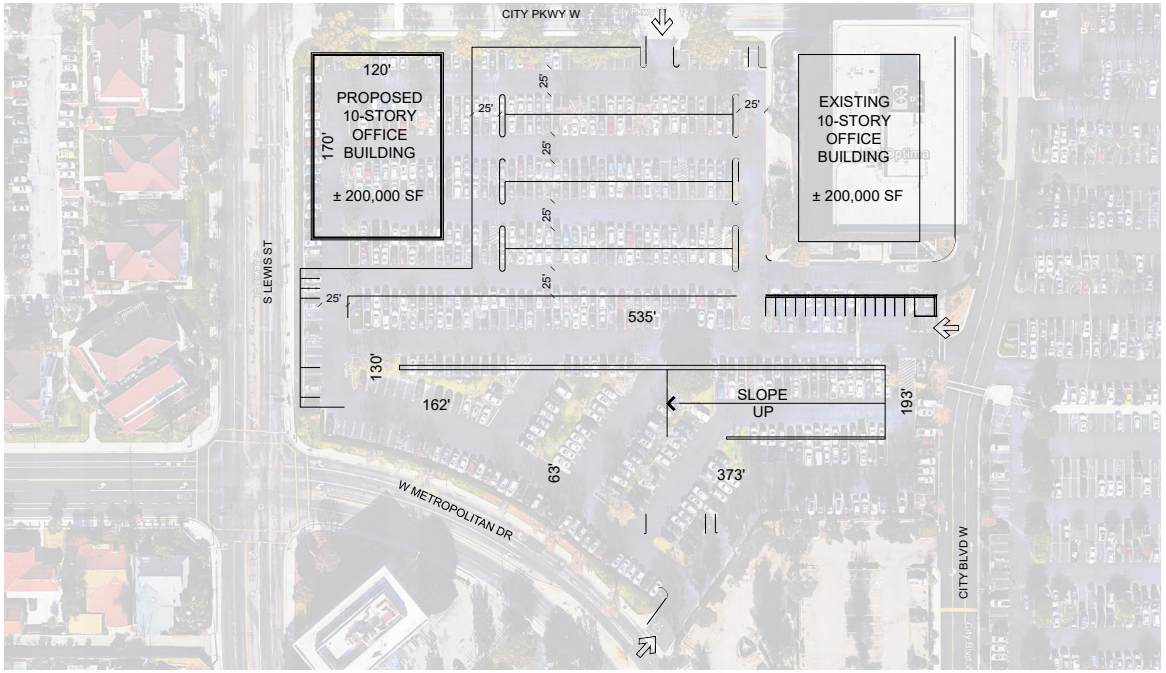
Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

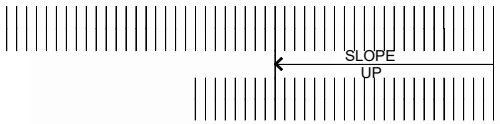
PROPOSED BUILDING: 200,000 SF

TOTAL BUILDING: 400,000 SF

F.A.R.: 1.46

PARKING REQUIRED: 2,000 STALLS
(400,000 SF @ 5/1000)

PARKING PROVIDED: ±2J032 STALLS
SURFACE: 192 STALLS
1ST FLOOR STRUCTURE: 240 STALLS
2-6TH FLOOR STRUCTURE: 1,450 STALLS
(290/STORY, TYP.)
7TH FLOOR: ±150 STALLS



TYPICAL PARKING LEVEL

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Development/Disposition Alternatives

RFP (Already Prepared)
- Direct Sale
- Ground Lease
- Joint Venture
- Trade of Nearby Property
  (Options to Occupy)

CalOptima Development/Construction
- Design/Bid/Build
- Design/Build
- Balance Sheet/Capital Implications
- Vacant Area Risk Assessment

Extend Development Agreement
- City Approval Required
- Fee Payment Likely Required

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Development Alternative Options

		Pros	Cons	Fiscal
Direct Sale:	CalOptima could directly sell the development rights and secure space for CalOptima's use.	1. Large one time capital infusion 2. Reserved right for additional space 3. No development risk	1. Loss of future control 2. Restricted expansion rights 3. Lease payments required on additional space	1. Large, one-time capital event 2. No on-going income 3. Lease payments for additional space
Ground Lease:	CalOptima could lease the property to a developer.	1. Long-term income stream 2. Reserved right for additional space 3. No development risk	1. Loss of future control 2. Restricted expansive rights 3. Lease payments required on additional space	1. Long-term income stream with periodic adjustments 2. Lease payments for additional space
Direct Development:	CalOptima could assign the development rights to a developer, who would provide space back to CalOptima in return.	1. Property is already owned by CalOptima 2. Current Entitlement already in place 3. Multiple delivery/financing options 4. Total flexibility with building design 5. Future expansion space 6. Inclusion of PACE 7. Incorporation of formal board space 8. Eliminate need for offsite leased space	1. Time to delivery: 22-30 months 2. Splits staff to 2 buildings 3. Capital requirement	1. Large capital expenditures for development required 2. No future rent payments 3. No lease payment for additional space 4. Lease income from expansion space tenants
Joint Venture:	CalOptima could develop the property jointly with a developer.	1. Participation in development Upside 2. Reserved right for additional space 3. Reduced development risk	1. Participation in development Downside 2. Some cash flow and development risks 3. No cash flow during development and lease-up period 4. Consistency with CalOptima core mission 5. Market Risk	1. Variable on-going income from project cash flow 2. No large capital contribution required
Exchange for Nearby Property:	CalOptima could exchange the development rights for a developed property	1. Ability to obtain pre-built expansion space 2. Likely "built-in" phased space availability 3. On-going cash flow	1. Market Risk 2. Building operations obligations 3. Value of suitable trade property	1. No large capital outlay 2. On-going income stream

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Conceptual Development Timeline

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Actions Related to CalOptima's Development Agreement with the City of Orange

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Receive and file the Property and Associated Development Rights Request for Information (RFI) results, dated April 21, 2017, that relate to property covered by CalOptima's existing development agreement at the 505 City Parkway West project site;
2. Authorize the Chief Executive Officer (CEO) to: ~~complete a Request for Proposal (RFP) process to select a real estate development consultant to assist CalOptima in:~~
    a. Contact the City of Orange (City) to explore:
        i. Extending CalOptima's existing development agreement for as long as possible (e.g., through 2026);
        ii. Broadening CalOptima's rights under the development agreement from commercial/office to include urban mixed use, including transitional housing; ~~the current Development Agreement with the City of Orange, which covers an office tower of up to 10 stories and a 1,528 space parking structure~~
    b. After confirming that the City is amenable to the proposed changes: ~~Developing a plan for moving forward with a parking structure~~
        i. Initiate a RFI process on development options for the site assuming the use of no Medi-Cal dollars and including a parking structure;
        ii. Seek assistance from the County of Orange Real Estate (Development Services) Department, as appropriate.
    c. ~~Conducting analysis and making recommendations on permissible options for further development of the site (e.g., Mixed Use, etc.), along with potential costs and funding mechanisms that would be associated with the exercise of each option.~~

Rev. 12/7/17

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to 10 stories and 200,000 square feet of office space, and a parking structure of up to five levels and 1,528 spaces. The office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the 505 City Parkway West building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014, meeting, the CalOptima Board of Directors authorized an amended and restated Development Agreement with the City of Orange to extend CalOptima's development rights for six

years, until October 28, 2020. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. CalOptima agreed to pay a required $200,000 public benefit fee to the City of Orange in exchange for the extension.

In 2016, at its August 4th and December 1st meetings, the Board authorized contracts with real estate consultant Newport Real Estate Services, Inc. to evaluate options for CalOptima's current development rights and to create a site plan. Newport Real Estate Services completed this analysis and presented the requested information to the Board's Finance and Audit Committee (FAC) in February 2017, and FAC recommended that the Board authorize issuance of a Property and Associated Development Rights Request for Information (RFI). The RFI was designed to gauge potential interest in and options for CalOptima's development rights. The Board approved the issuance of an RFI at its March 2, 2017, meeting.

By the close of the RFI response period on April 21, 2017, only one response had been received, from Trammel Crow Company. The RFI was narrowly focused on office space and parking, as per the current Development Agreement. This limited response to the RFI, as well as other informal discussions with industry representatives during the RFI process, may reflect the real estate community's limited level of interest in commercial office space at this time.

Discussion

In the years since the purchase of 505 City Parkway West, CalOptima's membership has grown significantly with the implementation of the Affordable Care Act. And while membership has been essentially stable in 2017, the operational and oversight demands have continued to grow, as have the number of programs the state has folded into the Medi-Cal managed care plans, in large part due to their member focus and cost effectiveness. While approximately 10% of the available 505 building workstations are currently unoccupied, the building is currently fully occupied as this "flex space" is critical to the Facilities Department's efforts to optimize available workspace to maximum workforce productivity (e.g., placing employees in a particular department in the same area/on the same floor of the building).

While CalOptima's existing office tower and employee workspaces are meeting current needs (with nearly one third of the staff in telework positions), it is anticipated that longer term, additional space may be required to meet the organization's needs. In the immediate term, parking is a pressing issue, with available spaces marginally adequate to meet parking needs during peak hours of operations. While management has explored a number of options to reduce the need to parking (e.g., further expansion of the telework program, carpools, vanpools, flexible start times, supporting alternative transportation, etc.), the need for additional parking is an increasingly pressing issue. One approach under consideration would be to recommend development of the parking structure initially, with a decision on the office tower development rights addressed at a later date.

Regarding the potential development of a second ten story office tower at this time, with the assumption that it would at least initially be partially occupied by third parties, various market factors suggest that growth in demand for professional office space by third party tenants in the North Orange County region appears somewhat limited, though in the immediate area, virtually all available commercial space is currently occupied. According to a Second Quarter 2017 analysis by Colliers

International, market activity has slowed compared with the past two years. Staff's understanding is that average lease rates in the North Orange County area remain at approximately $2.23 per square foot, which is below their 2007 peak. Staff also believes that, while there are a number of large developments in the works for central Orange County, the majority of new, large scale professional office projects in the county are proposed within the John Wayne Airport and South Orange County areas as opposed to the North Orange County region. These trends may limit the value of CalOptima's current Development Agreement if the decision is to develop the site as a 10-story commercial building that will, in part, be leased to third parties.

To ensure that a comprehensive review process is completed before a decision is made on the best use of the new tower site, staff is recommending that the Board obtain the expertise of a real estate development consultant to evaluate the potential value of a revised Development Agreement that would allow for other potential uses such as, for example, Urban Mixed-Use zoning, which would include commercial retail and housing uses. While this approach may result in the facility being sold to a third party, it assumes that CalOptima will make other arrangements to meet any increases in need for office space as the current facility is near capacity today. Though it is possible that the commercial vacancy rate in the area may increase in the future, when CalOptima was considering additional space approximately two years ago, very limited space was available within several miles of the 505 building. At this stage, one possible approach the consultant could explore would be to focus on prioritizing the additional parking space now, and either seeking an extension of the remaining rights as further study is completed on the available options, or estimating the cost of seeking a change to the Development Agreement to allow for Mixed Use zoning. Another option would be to sell the rights to a third party who may be interested in exercising the existing development rights, or pursuing a change with the City of Orange.

Fiscal Impact

The FY 2016-17 Board-approved CalOptima Medi-Cal operating budget includes $37,000 for Real Estate Consultant services. In addition to this amount, once the scope of work for the consultant is developed, staff will return to Board with an estimate of additional costs.

California Welfare and Institutions Code section 14087.54, CalOptima's enabling statute, provides that CalOptima was established to "meet the problems of delivery of publicly assisted medical care in the county… and to demonstrate ways of promoting quality care and cost efficiency." The statute also includes provisions limiting the use of "any payment or reserve from the Medi-Cal program" to administration of the Medi-Cal program itself. Consequently, alternative funding (i.e., from a source other than CalOptima) would be an essential element of any recommendation to use the development rights for some purpose not specifically related to CalOptima's administration obligations under the Medi-Cal program.

Rationale for Recommendation

In order to assist the Board in determining next steps with the existing Development Agreement with the City of Orange, staff recommends engaging a real estate consultant.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated March 2, 2017, Consider Options for Development Rights at 505 City Parkway West, Orange, California Site
    a. Amended and Restated Development Agreement dated December 10, 2014
2. Notice of Request for Information #17-031, dated March 20, 2017, Amendment No. 1, for Property and Associated Real Estate Development Rights
3. Response to Request for Information: Property and Associated Real Estate Development Rights, TrammellCrowCompany, dated April 21, 2017
4. California Welfare and Institutions Code section 14087.54

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Options for Development Rights at 505 City Parkway West, Orange, California Site

Contact
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO) to issue a Request for Information (RFI) to solicit responses regarding potential interest and options for CalOptima's development rights with results to be presented to the Board at a future date.

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the "605 Building Site." At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the Board authorized the CEO to enter into an Amended and Restated Development Agreement with the City of Orange to extend CalOptima's development rights for up to six additional years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At its August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

At the December 1, 2016 meeting, the Board authorized a contract amendment with real estate consultant, Newport Real Estate Services (NRES), to include site plan development and expenditures from existing reserves of up to $7,000 to fund the contract amendment.

Discussion
At its February 16, 2017 meeting, the Board of Directors' Finance and Audit Committee (FAC) received presentations from CalOptima management and real estate consultant, NRES. The presentation included an update on CalOptima's staffing needs and space alternatives, a review of a site plan developed by NRES, options for exercising the development rights with pros and cons of

certain options, and a preliminary timeline. In addition, FAC members discussed the need to gather more information and to gauge potential interest on the following options: Direct Sale, Ground Lease, Joint Venture, and Property Trade.

An additional option is pursuing an extension of the current Development Agreement for an additional 3 years beyond 2020. This option would require approval by the City of Orange, and would likely require CalOptima to make additional public benefit fee payments. In the event the Board elects to pursue this option, and the City of Orange is agreeable to the extension, Staff will return to the Board to present applicable proposals.

Fiscal Impact
The recommended action to issue an RFI for development rights is budget neutral.

Rationale for Recommendation
The Development Agreement with the City of Orange provides CalOptima the opportunity to provide for future space needs in the event CalOptima requires additional office space. At the same time, the development rights are a valuable asset that can be severed from the existing parcel if CalOptima finds that CalOptima's construction of a separate office building and parking structure is not practical, feasible, or otherwise in the best interest of the organization. Management recommends that the Board authorize the CEO to issue an RFI to fully explore potential interest and options available with the existing development rights.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
2. CalOptima Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
3. NRES PowerPoint Presentation to the Board of Directors' Finance and Audit Committee dated February 16, 2017: Long-Range Strategic Real Estate Plan – Excess Real Estate Development or Disposition Update

/s/ Michael Schrader — *2/23/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

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Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

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Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

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(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

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(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

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(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

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otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

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Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

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DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

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ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

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EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

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widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

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ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

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EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

LONG-RANGE STRATEGIC REAL ESTATE PLAN – EXCESS REAL ESTATE: DEVELOPMENT OR DISPOSITION - UPDATE

- FINANCE AND AUDIT COMMITTEE MEETING
- FEBRUARY 16, 2017
- GLEN ALLEN, PRESIDENT
- NEWPORT REAL ESTATE SERVICES, INC.

NEWPORT Real Estate Services, Inc.®

Purpose of Presentation

- CalOptima Staffing Needs
- Review Site Plan
- Review Development Rights Options: Pros/Cons
- Review Development Rights Timeline
- CalOptima Development vs. 3rd Party Disposition

NEWPORT
Real Estate Services, Inc.®

Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

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Needs Assessment - Assumptions

- Optimized Telecommuting
- Assumes Projected Programs
  - Cal-MediConnect
  - Medi-Cal
  - OneCare
  - PCC Program
  - ACA Related and Demographic-Trend Member Growth
- Recapture of all 505 Space
- 1 person/181 s.f. space allocation

NEWPORT
Real Estate Services, Inc.®

Current Space Projection

505 Building Available Seats	
On Site	749
Filled Seats	46
Sub-Total	**795**
Teleworker/Community	318
Total	**1,114**
Total Space Available	**1,025**
Filled Seats and Temp Help	(795)
Total Vacant Spaces	**257**
Pending Requests to Fill	(142)
Expected Employee Count for New Programs	(26)
Net Space Surplus (Shortfall)	**89**
10th Floor Space	85
Total Surplus (Shortfall)	**174**

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Real Estate Services, Inc.®

Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

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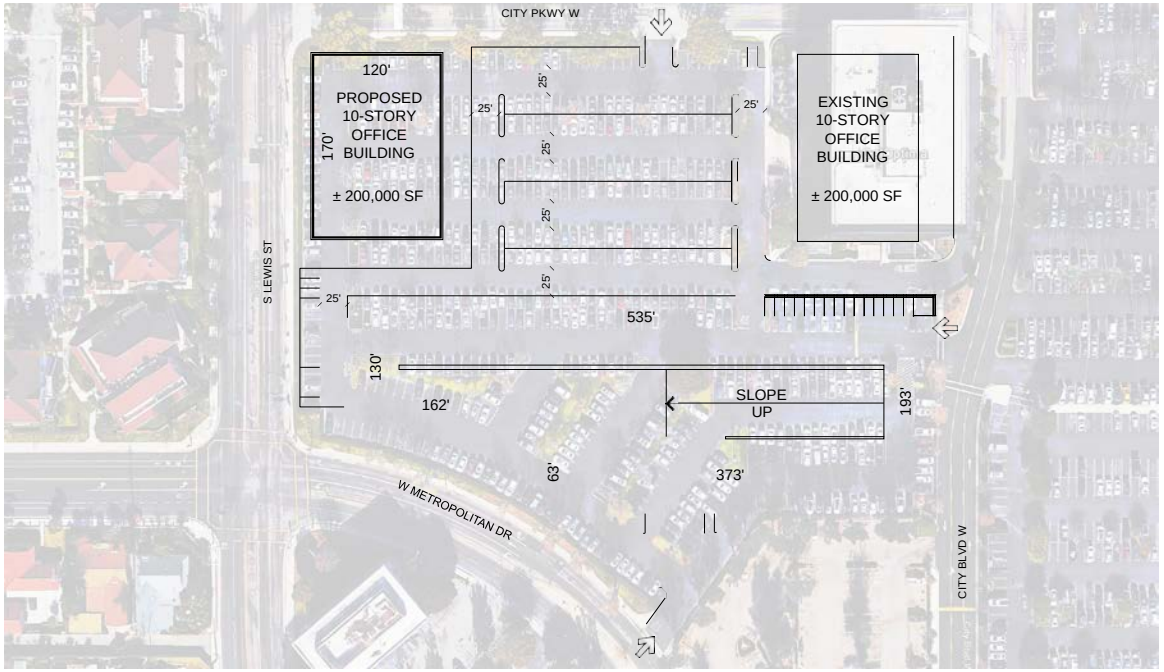
Real Estate Services, Inc.®

Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

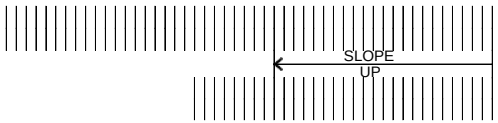
PROPOSED BUILDING: 200,000 SF

TOTAL BUILDING: 400,000 SF

F.A.R.: 1.46

PARKING REQUIRED: 2,000 STALLS
(400,000 SF @ 5/1000)

PARKING PROVIDED: ±2J032 STALLS
- SURFACE: 192 STALLS
- 1ST FLOOR STRUCTURE: 240 STALLS
- 2-6TH FLOOR STRUCTURE: 1,450 STALLS
  (290/STORY, TYP.)
- 7TH FLOOR: ±150 STALLS



TYPICAL PARKING LEVEL

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Development/Disposition Alternatives

RFI (To be Prepared)
- Direct Sale
- Ground Lease
- Joint Venture
- Trade of Nearby Property
  (Options to Occupy)

CalOptima Development/Construction
- Design/Bid/Build
- Design/Build
- Balance Sheet/Capital Implications
- Vacant Area Risk Assessment

Extend Development Agreement
- City Approval Required
- Fee Payment Likely Required

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Development Alternative Options

		Pros	Cons	Fiscal
Direct Sale:	**CalOptima could directly sell the development rights and secure space for CalOptima's use.**	**1. Large one time capital infusion 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansion rights 3. Lease payments required on additional space**	**1. Large, one-time capital event 2. No on-going income 3. Lease payments for additional space**
Ground Lease:	**CalOptima could lease the property to a developer.**	**1. Long-term income stream 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansive rights 3. Lease payments required on additional space**	**1. Long-term income stream with periodic adjustments 2. Lease payments for additional space**
Direct Development:	**CalOptima could assign the development rights to a developer, who would provide space back to CalOptima in return.**	**1. Property is already owned by CalOptima 2. Current Entitlement already in place 3. Multiple delivery/financing options 4. Total flexibility with building design 5. Future expansion space 6. Inclusion of PACE 7. Incorporation of formal board space 8. Eliminate need for offsite leased space**	**1. Time to delivery: 22-30 months 2. Splits staff to 2 buildings 3. Capital requirement**	**1. Large capital expenditures for development required 2. No future rent payments 3. No lease payment for additional space 4. Lease income from expansion space tenants**
Joint Venture:	**CalOptima could develop the property jointly with a developer.**	**1. Participation in development Upside 2. Reserved right for additional space 3. Reduced development risk**	**1. Participation in development Downside 2. Some cash flow and development risks 3. No cash flow during development and lease-up period 4. Consistency with CalOptima core mission 5. Market Risk**	**1. Variable on-going income from project cash flow 2. No large capital contribution required**
Exchange for Nearby Property:	**CalOptima could exchange the development rights for a developed property**	**1. Ability to obtain pre-built expansion space 2. Likely "built-in" phased space availability 3. On-going cash flow**	**1. Market Risk 2. Building operations obligations 3. Value of suitable trade property**	**1. No large capital outlay 2. On-going income stream**

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Conceptual Development Timeline

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CalOptima
Better Together

March 20, 2017

Amendment No.1
NOTICE OF REQUEST FOR INFORMATION (RFI)

#17-031

GENERAL CONDITIONS AND INSTRUCTIONS TO RESPONDENTS

For

PROPERTY AND ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

Key RFI Dates

Written Questions Due: March 30, 2017, 12:00 p.m. Pacific Time
Proposal Submittal Date: April 21, 2017, 12:00 p.m. Pacific Time

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SECTION I: INSTRUCTIONS AND CONDITIONS

1. GENERAL INFORMATION

1.1. The purpose of this Request for Information (RFI) is to seek background information from qualified real estate developers regarding their interest in a potential real estate agreement with regard to CalOptima's Real Estate Development rights located at 605 City Parkway West, Orange, CA 92868.

1.2. THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes to assist CalOptima in finalizing the scope of work and requirements which may be used at a future date in the issuance of a Request for Proposal (RFP). It does not constitute a Request for Proposal (RFP) or a promise to issue an RFP in the future. This request for information does not commit CalOptima to contract for disposition whatsoever. Further, CalOptima is not at this time seeking proposals and will not accept unsolicited proposals. Respondents are advised that CalOptima will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future RFP. If a solicitation is released, it will be released through BidSync. It is the responsibility of the potential Respondent to monitor this site for additional information pertaining to this requirement.

2. POINT OF CONTACT

All communications relating to this RFI must be directed to CalOptima's designated contact below:

Kim Marquez
Senior Buyer
CalOptima Vendor Management Department
Kmarquez2@CalOptima.org

3. QUESTIONS AND CLARIFICATIONS

3.1. If a Respondent desires an explanation or clarification of any kind regarding any provision of this RFI, the Respondent must generate a written request for such explanation or clarification through BidSync by March 30, 2017, 12:00 p.m. Pacific time.

3.2. Inquiries received after March 30, 2017 12:00 p.m. Pacific time will not be responded to. Inquiries received by email to the contact above will not be responded to. All questions should be directed to CalOptima through BidSync.

3.3. CalOptima responses to questions will be communicated via BidSync, and will be sent no later than April 5, 5:00 p.m. Pacific time.

4. RESPONSES

Interested parties are requested to submit their response through BidSync no later than April 21, 2017, 12:00 p.m. Pacific Time. Information submitted outside of Bidsync will not be considered.

5. USE OF RESPONDENT'S RESONSE AND ACCOMPANYING MATERIAL

5.1. All materials submitted become the property of CalOptima and will not be returned. If the Respondent intends to submit confidential or proprietary information as part of its response, any limits on the use or distribution of that material should be clearly delineated in writing. However, CalOptima is a public agency and therefore subject to the California Public Records Act (California Government Code, Section 6250 et seq).

5.2. CalOptima will use reasonable precautions allowed by law to avoid disclosure of the Respondent response. CalOptima reserves the unrestricted right to copy and disseminate the Respondents response for internal review and for review by external advisors, at CalOptima's sole discretion.

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6. INDUSTRY DISCUSSIONS

CalOptima representatives may or may not choose to meet with Respondents. Such discussions would only be intended to get further clarification of potential capability to meet the requirements.

7. SUMMARY

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY to identify available opportunities in the market as well as resources that can provide information regarding the CalOptima Real Estate Development rights. The information provided in the RFI is subject to change and is not binding on CalOptima. CalOptima has not made a commitment to contract for any of the items discussed, and release of this RFI should not be construed as such a commitment. All submissions become CalOptima property and will not be returned.

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SECTION II: CALOPTIMA BACKGROUND AND OVERVIEW

1. County Organized Health Systems (COHS) Background

The California State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972, Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category.

In June 1983, a new type of managed care program, the County Organized Health System (COHS), became operational. The COHS managed care model ensures Med-Cal recipients access to comprehensive, cost-effective health care. Each COHS plan is sanctioned by the County Board of Supervisors and governed by an independent commission.

2. CalOptima Overview

CalOptima's Overview can be located by clicking on the following link and by selecting 'View CalOptima Fast Facts": https://www.caloptima.org/AboutUs.aspx

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SECTION III: GENERAL REQUIREMENTS

1. BUSINESS OBJECTIVES/TIMING

CalOptima is considering monetizing the additional available land and entitlement rights located adjacent to its headquarters building located at 505 City Parkway West, Orange, California. CalOptima has the following key objectives:

1.1. Monetizing this asset while the development rights are still available;

1.2. Providing for potential additional expansion space to meet CalOptima's chartered goals and objectives.

While CalOptima has the ability and resources to develop the parcel internally, there may be significant advantages to having this development be completed through a sale (with leaseback opportunities), joint venture or other financial structure with a third-party.

The primary objective of this RFI is to begin to collect information on third parties that may be potentially interested in acquiring, joint venturing, trading or otherwise assist CalOptima in monetizing this asset.

While no particular timeframe has been established, the initial goal would be to enter into an agreement with a third-party that would allow for the development and construction of the building before expiration of the development rights in October, 2020.

As one of CalOptima's stated goals is to provide for the potential expansion of its workforce in furtherance of its core mission, and development rights for an additional office building are currently in place, CalOptima will only consider expressions of interest, and ultimately development of a class A office building of a type that is similar in quality and configuration to its existing 505 Building. Parties interested in land-use conversion (i.e. apartments or high density residential) should not respond to this RFI, as any such proposed uses will be dismissed without comment.

2. PROJECT OVERVIEW/BACKGROUND

CalOptima acquired the real estate development rights in 2014. The original development of the property site contemplated future construction of an additional 10 story 200,000 SF building to be known as 605 City Parkway West, Orange, CA, as well as an adjacent parking structure, which would accommodate both 505 and 605 buildings.

The objective of this RFI is to collect information from potential interested parties that might help CalOptima achieve these goals.

CalOptima is willing to consider a variety of potential real estate transaction structures. Responders are encouraged to address each of the alternatives outlined below. CalOptima does not, at this time, have a preferred structure. CalOptima will evaluate each of the responses in the interest of obtaining the greatest economic and intrinsic benefit to CalOptima. Respondents are also encouraged to propose alternative ideas that may be of interest to CalOptima.

CalOptima predicts that it may need additional space beyond its corporate headquarters, over time. As such, a continuing right, but not the obligation, to occupy space in the future building to be constructed by Offeror on the Excess Land may be of significant interest to CalOptima.

3. Considerations

3.1. Direct Fee Purchase: CalOptima may consider a direct fee purchase of the Excess Land and associated entitlements. Respondent's proposal for this approach must include estimates of

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proposed purchase price, transaction timing, and other general provisions of Respondent's proposal.

3.2. Ground Lease/Participating Ground Lease: CalOptima may consider a ground lease of the Excess Land. In the case of a ground lease, or participating ground lease proposal, the Offeror should include an estimated initial base rent, lease term and lease payment commencement, proposed escalation, ground lease term, subordination (an unsubordinated ground lease is strongly preferred), and other general terms of the ground lease/participating ground lease. In the event Offeror proposes a participating ground lease, Offeror's proposal should include minimum rent, percentage participating, formula and basis for participation as well as the other terms addressed in the fixed ground lease proposal.

3.3. Joint Venture: While a joint venture between a private-sector entity and a public agency does present its challenges, CalOptima wants to remain flexible with regard to potential transaction structures that may enhance cash flow, flexibility and overall economic benefit for the agency. Respondents proposing a joint venture structure should address joint venture structure preferential rates of return, capital contribution values, distribution priorities and capital risk exposure. Please keep in mind that CalOptima will require that its equity value be in first priority and not subject to foreclosure risk.

3.4. Potential Trade: As part of its mandated healthcare delivery mission for the residents of Orange County, CalOptima anticipates that its staffing levels may continue to increase over the coming years. While CalOptima does not occupy all of the current building, it anticipates that as a space in the building is recaptured, its space needs may exceed the capacity of the current building. As such, acquisition of a nearby, preferably, adjacent building may be of interest to CalOptima. Respondents that currently own a nearby building may want to consider proposing a trade of the Excess Land for such a building. Respondents considering this approach should address: the location and physical condition of the trade property, any existing leases or other restrictions on occupancy, building condition, and terms of trade.

4. Highlights of CalOptima's Development Rights Agreement

4.1. Development Agreement

a. Rights for development of the "605 Building" and related parking structure. Development rights for the referenced City Plaza Two Site were subsequently assigned to another developer (see Estoppel Certificate).

b. Section 1(j)(2)(B) - CUP for 605 Building site (approved by City Council 10/9/01) – 10 story, 200,000 SF building and a 5-level, 1,528 space parking structure.

c. Section 1(j)(3)-(6) – Cost sharing with other projects for area traffic improvements and widening of Orangewood Avenue bridge over the Santa Ana River (should be no exposure to such costs if development does not occur at the 605 Building site).

d. Section 7(e) – Good Faith Efforts Regarding Block of Orange Expansion – Mentions CC&R's of "The City" (to be further researched).

e. Section 12 – Term expires 10/28/19.

f. Section 14(a) – Covers assignment for a portion of the project sold; requires 30 day notification by Seller and Purchaser is to agree in writing to be subject to terms of the Agreement.

g. Section 14(b) – Reference is made to responsibility for reporting and annual review requirements (to clarify).

h. Public Benefit Fees. Fees would have needed to be paid in order to keep the Agreement active, including library and park related fees.

a. Prior to obtaining a certificate of occupancy, separate $25,000 fees would be required for two City of Orange Foundations.

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4.2. First Amendment to Development Agreement – Executed 1/20/06:

a. Public Benefit Fees Payable - $15,000 of a $100,000 Park Fee to be paid within two business days of receiving a building permit for the 605 Building.

4.3. Second Amendment to Development Agreement

a. Amended Exhibit D is provided for, with remaining applicable fees being as follows

1. $15,000 Library Fee (15% of $100,000) and $15,000 Park Fee (15% of $100,000) within two business days of receiving a building permit for the 605 Building.

2. If the Agreement has not been terminated and an agreement has not been reached with the Block owner regarding certain elements of the proposed Block expansion, prior to obtaining a certificate of occupancy, separate $25,000 fees would be required for two City of Orange Foundations; and

3. Commencing on the Second Resolution Effective Date (5/30/07) and each anniversary thereof, continuing through the initial term (10/28/14), a $30,000 fee is required.

4.4. Operating Memorandum – Executed 1/22/07:

a. Block expansion plans were modified and CC&R's were amended by Block ownership and the City Parkway ownership at the time.

b. City Parkway owner relieved of any or all of the Public Benefit Fees.

4.5. Estoppel Certificate – Provided by City of Orange to the Current Ownership, 5/13/09:

a. Indicates Maguire assigned its rights to the City Plaza Two Site in August 2008 to HFOP City Plaza, LLC.

b. Acknowledges there were no Public Benefit Fees or other development, traffic mitigation or processing fees due from Maguire (seller) at that time.

c. Certificate shall inure to the benefit of Purchaser, Lender and their respective successors and assigns.

4.6. Conditional Use Permit – Resolution No. PC 19-01 (as referenced in Section 1(j)(2)(B) of the Development Agreement):

a. Approval for a 10-story, 200,000 SF office building and 5-level, 1,528 space parking structure, subject to several conditions and mitigation measures outlined in the CUP.

5. SUGGESTED CONTENT OF RESPONSE

CalOptima is asking interested Respondents to submit a response containing, at a minimum, the following information.

5.1. General Respondents Information

a. Explain the reason for your firm's interest in possibility providing the services listed within this RFI.

b. Name and contact information of person we can contact if we have questions.

c. Brief history of your firm.

d. Brief description of past experience providing similar services.

5.2. Additional Questions

a. Provide any comments, observations or suggestions which may assist CalOptima in drafting a procurement solicitation.

b. Please provide a brief summary of how you might envision the transaction structures that your firm would propose.

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c. If possible, please provide preliminary economic results of how you might see a transaction being structured.

d. Please provide a potential timeline for any of the structures that you believe might be appropriate for your firm.

e. Please outline the obligations that your firm would request of CalOptima as part of any transaction structure.

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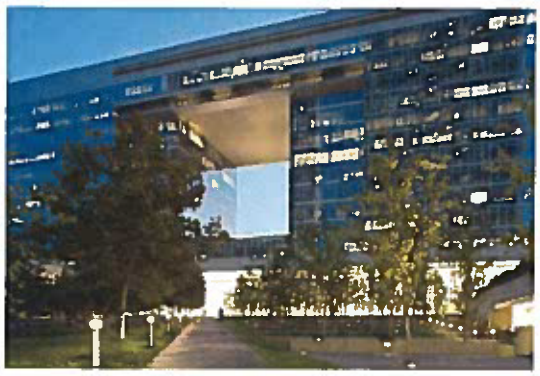
RESPONSE TO REQUEST FOR INFORMATION:

PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

605 CITY PARKWAY WEST, ORANGE, CA



PRESENTED TO:

CalOptima
A Public Agency
Better. Together.

PRESENTED BY:

Trammell Crow Company

APRIL 21, 2017

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Tom Bak
Senior Managing Director
Trammell Crow Company
Development and Investment

Trammell Crow Company

3501 Jamboree Road, Suite 230
Newport Beach, California 92660

Work: 949.477.4702
Fax: 949.477.9107

tbak@trammellcrow.com
www.trammellcrow.com

April 21, 2017

Ms. Kim Marquez
Senior Buyer
CalOptima Vendor Management Department
505 City Parkway West
Orange, CA 92868

RE: Response to RFI for Property & Associated Real Estate Development Rights at 605 City Parkway West

Dear Ms. Marquez:

We are pleased to formally provide this Response to Request for Information for the Property and Associated Real Estate Development Rights located at 605 City Parkway West in the City of Orange.

The Trammell Crow Company is widely recognized as the Nation's largest developer by total product under construction, and has been ranked #1 for the past three consecutive years in Commercial Property Executive Magazine's 2014, 2015, & 2016 list of national developers. The proposed team highlighted in this proposal offers local Class A Office Development experience backed by a nationally renowned organization.

In the pages that follow, you will find a detailed response that seeks to emphasize the following key elements that we believe position our team to provide CalOptima with the highest level of service and certainty of performance:

Local Presence & Experience: Trammell Crow Company has had a strong presence in Southern California since 1972. Our SoCal team is currently comprised of 28 real estate professionals who cover Orange County, Los Angeles, San Diego, and the Inland Empire. Over the last few years, while many of our competitors have disappeared, our balanced business model combining development with acquisitions has allowed us to thrive and gain substantial market share. Our Southern California team has experience building and entitling well over 100 projects across class "A" office, healthcare, industrial, retail, mixed use, and residential product types.

Office Development Expertise: Trammell Crow Company's Southern California Development & Investment team has an established reputation in Class-A office development, with individuals who dedicate their entire practice to the successful execution of office projects, specifically development and leasing. In just the past ten years, we have developed a diverse array of office product, including speculative, build-to-suit, ground-up and redevelopment, totaling 1.9M SF and valued at over $1.3 billion.

Public Agency & Government Collaboration: Our Team has a proven track record of successfully working with local governments on the acquisition, ground-leasing, development, planning, construction, leasing, and property management of office buildings leased to public agencies and governmental tenants. We are also experts in developing strategies for designing, financing and constructing projects that serve as sources of economic development for the surrounding community. These buildings are compelling places to work as well as sources of community identity and renewal.

Our team offers extensive Southern California development experience, a strong history of partnerships with governmental clients, design-build expertise, ability to independently finance the project, and, most importantly, a culture of honesty and dedication with a commitment to exceeding client expectations. We greatly appreciate your consideration and the opportunity to work with CalOptima on this exciting piece of property. We look forward to meeting with you to discuss our proposal. If you have any questions regarding the attached proposal, please do not hesitate to contact me.

Warm regards,

Tom Bak
Senior Managing Director

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PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS
605 CITY PARKWAY WEST, ORANGE, CA

Trammell Crow Company

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SECTION 1. GENERAL RESPONDENTS INFORMATION

A. EXPLAIN THE REASON FOR YOUR FIRM'S INTEREST IN POSSIBILITY PROVIDING THE SERVICES LISTED WITHIN THIS RFI.

Since 1948, Trammell Crow Company (TCC) has consistently been viewed as a leader and innovator within the real estate development industry. The organization has built it's reputation by focusing on building the best product in the best location. Our Southern California Business Unit has been continually developing successful Class A office product on both a build-to-suit and speculative basis, throughout each of the past ten years, totaling the successful delivery and leasing of over 1.35M SF of office space since 2007, with another 550K SF on track to be completed later this year.

TCC has a long, successful reputation of development within Orange County, and is extremely bullish on this market. We are currently under construction on the largest speculative ground up office development in Southern California. As such, we are in contact with every tenant in the market that is looking for new, high quality work space. We view this as a tremendous opportunity to deliver Class-A office product to the Central County marketplace due to the asset's:

Premier Location: The subject property's premier location in the heart of the City of Orange, adjacent to existing Class A office product, and a surplus of amenities within walking distance makes this an ideal opportunity to provide the newest product to Central Orange County. TCC previously developed the Arena Corporate Center, a 385,000 SF nearby Class A office park, with significant success and has actively been searching for another opportunity in the sub-market.

In-Place Entitlements: The existing entitlements for the project offer a tremendous opportunity to deliver high quality space in a market that has seen minimal development in the past several years. Speed to market is essential in satisfying the needs of tenants in search of space.

We are confident that not only does this particular property offer tremendous potential to satisfy the needs of Orange County's tenant base, but TCC is the ideal group to strategically position, design, develop, and lease this excellent asset with a reputation of:

Successful Collaboration & Partnership with Public Agencies: TCC has worked with numerous governmental and public agencies to entitle, finance, design, and develop numerous Class-A projects throughout Southern California. As detailed in the following case studies, in the past 10 years alone, the TCC Southern California team has successfully completed five built-to-suit office projects, totaling approximately 600,000 SF, and is nearing start of construction on a 200,000 SF, highly customized Medical Office Building for the County of Riverside.

Consistent On-time & On-budget Deliveries: Whether CalOptima determines a need for additional space, or the entire building is ultimately marketed to the outside community, every tenant depends upon a reliable budget and schedule. TCC has a proven track record for delivering projects on-time and on-budget, resulting in consistent repeat business with our clients.

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B. Name and contact information of person we can contact if we have questions.

Profiles for the primary members of the development team that would be dedicated to this project are included on the following pages. David Nazaryk , Managing Director, will serve as Primary Point of Contact.

DEVELOPMENT TEAM

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
2000 Avenue of the Stars
Arena Corporate Centre
Pacific Vista
Kendall Healthcare BTS
Burbank Airport Plaza
Main Street District Center
California Palms Business Center
Sycamore Business Park
Knox Logistics Center
1-215 Logistics Center
Westec BTS
Centrepointe Chino I
Gateway Diamond Bar
Harman International Campus
Irwindale Business Center I
Irwindale Business Center II
Centrepointe Chino II

TOM BAK
SENIOR MANAGING DIRECTOR
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4702
tbak@trammellcrow.com

Tom Bak is Senior Managing Director of Trammell Crow Company where he serves as a member of the firm's Operating Committee and as a subject matter expert for the National Investment Committee. In his capacity as Senior Managing Director, Tom is responsible for raising capital, setting investment strategy, creating deal flow, negotiating and structuring transactions, advising on financing, asset management and property-related issues, and overseeing the day to day activities of Trammell Crow's Southern California Development & Investment professionals.

EXPERIENCE

Under Tom's leadership, the Southern California Development & Investment Group has completed, or is in the process of completing, the acquisition and development of office, industrial and brownfield projects totaling over 20 million square feet and representing investments of over $1.5 billion from public and corporate pension funds, insurance companies, REITs, Taft Hartley funds, endowments and high net worth partners.

Tom began his career with Trammell Crow Company as a leasing agent. He has received numerous regional and national awards recognizing his achievements as a top leasing and development producer. In 1989, he became one of the youngest partners in the firm. In 1996, Tom became leader of the Southern California Development & Investment Group.

EDUCATION & CREDENTIALS

University of California Los Angeles, MBA
Amherst College, B.A.

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Past President, National Association of Industrial and Office Properties (NAIOP) - Los Angeles Chapter
NAIOP I.CON Conference Speaker, Industrial Trends
University of California - Irvine, Center for Real Estate Advisory Board
Urban Land Institute Conference Speaker, Office Building Design Trends
Pension Real Estate Association (PREA), Developer Affinity Group
St. Joseph Hospital, Planning and Community Benefits Committees

Trammell Crow Company

DEVELOPMENT TEAM (PRIMARY POINT OF CONTACT)

DAVID NAZARYK
MANAGING DIRECTOR
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4732
DNAZARYK@TRAMMELLCROW.COM

David has developed much of TCC's portfolio in Southern California since joining the company in 1996. He also manages the operations of the group. He is responsible for sourcing, underwriting, financing and developing office and industrial projects throughout the Southern California region.

Through his relationships with the brokerage network, governmental officials and capital partners, David has seamlessly and successfully completed some of the largest and most complicated projects within the TCC national portfolio. He has structured and documented numerous development projects with TCC's existing investment relationships and has forged new ones for the company. He is also highly regarded in the company for his unique ability to craft and execute complicated built-to-suit projects. His reputation is one of over-delivering on his promise and providing maximum returns on a variety of real estate development projects. His efforts have been recognized locally and nationally by colleagues through NAIOP Best Project, San Gabriel Valley Best Developer and numerous other awards.

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
2000 Avenue of the Stars
Arena Corporate Centre
Pacific Vista
Kendall Healthcare BTS
Westec BTS
Centrepointe Chino I
Gateway Diamond Bar
Harman International Campus
Irwindale Business Center I
Irwindale Business Center II
Centrepointe Chino II
Burbank Airport Plaza
Main Street District Center
California Palms Business Center
Sycamore Business Park
Innovation Village Research Park
Knox Logistics Center
I-215 Logistics Center

EXPERIENCE

Trammell Crow Company – Southern California– 1996 to Present
Managing Director

- Successfully master planned 10,600,000 SF and developed 6,000,000 SF of office and industrial projects throughout Southern California.
- Established land use designs and/or development plans through selecting, supervising and directing required consultants.
- Negotiates with cities and other governmental agencies to obtain appropriate development mix, entitlements, and land use design standards.
- Effectively markets specific projects such as land, speculative development or build-to-suit, for lease or sale.
- Coordinates all stages of off-site and on-site construction, including tentative and final parcel maps, infrastructure and utility drawings, street and utility construction, preliminary building site plans or office floor plans, working drawings, permit process, construction bidding, on-site shell and tenant improvement construction, Certificate of Occupancy and punch-list completion.
- Provides value engineering through construction experience and local consultant expertise.

Catellus Development Corporation – 1983 to 1996
Project Director

EDUCATION & CREDENTIALS

Evangel College, Springfield, MO, B.A., 1983

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Board of Directors, American Red Cross
Member, National Association of Industrial and Office Properties
Member, Urban Land Institute

Trammell Crow Company

DEVELOPMENT TEAM

MATT CRAMER
SENIOR VICE PRESIDENT
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4735
mcramer@trammellcrow.com

Matt is a recognized industry leader in office product and often lends his expertise to other TCC business units. Matt's strengths include deal underwriting, securing of entitlements, comprehensive development management, pre-construction programming, design-build and construction management. His career path has included various positions from project superintendent to development manager and he is known for his ability to manage and execute difficult projects on time and on budget.

Matt brings more than 25 years of development and construction expertise to Trammell Crow Company. During his career, he has managed development and/or construction of over 9,000,000 square feet of office buildings, parking structures, mixed-use projects, industrial buildings, high tech facilities and public facilities, ranging from $5 million to over $300 million from conception to project completion. Matt is a recognized industry leader in office product and often lends his expertise to other TCC business units. Matt's strengths include deal underwriting, securing of entitlements, comprehensive development management, pre-construction programming, design-build and construction management. His career path has included various positions from project superintendent to development manager and he is known for his ability to manage and execute difficult projects on time and on budget.

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
Phase 3, 4, & 5
Washington Mutual Irvine
Office Expansion
Opus Center Irvine Phase I & II
Fairway Center II
Summit Phase I
Westec Orange County
Communications
Galaxy Latin America
Cabot, Cabot & Forbes
Corporate Center
South Coast Metro Center
I-215 Amazon BTS
Amazon Fulfillment Center
Redlands Business Park
Magnolia Point

EXPERIENCE

Trammell Crow Company – Newport Beach, CA – 2005 to Present
Senior Vice President, Development Management

Howard S. Wright Construction Company – 2003 to 2005
Project Executive/Business Unit Manager

Opus West Construction Corporation – 1998 to 2003
Senior Project Manager

L.E. Wentz Company – 1997 to 1998
Senior Project Manager

ARB, Inc. – 1995 to 1997
Project Manager

Turner Construction Company – 1987 to 1995
Project Superintendent

EDUCATION & CREDENTIALS

California State University, Long Beach, B.S., Construction Management

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Member, NAIOP, SoCal and Inland Empire chapters
Advisory Council Member, California State University Long Beach School of Engineering
Member, Trammell Crow Company National LEED® "Green Task Force"
State of CA Registered Disaster Service Worker, OES Certified Safety Assessment Volunteer
Step Up On Second Charitable Organization, Past Chairman, Board of Directors

Trammell Crow Company

DEVELOPMENT TEAM

PROJECT DEVELOPMENTS

The Boardwalk

County Law Building

Gateway at Alhambra

Ontario Innovation Center I & II

Knox Logistics Center

1-215 Logistics Center

Magnolia Point

Innovation Village 5

CHRIS TIPRE
SENIOR VICE PRESIDENT
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4717
ctipre@trammellcrow.com

Chris serves as Senior Vice President for Trammell Crow Company's Southern California Business Unit in Newport Beach, California. He is responsible for land and deal sourcing, financial analysis, due diligence, entitlements, capital relationships, development coordination, and project marketing and leasing.

EXPERIENCE

Trammell Crow Company – Newport Beach, CA – 2011 to Present
Senior Vice President

- Responsible for management of finance, marketing, leasing, development and operations of 545K SF Class A speculative office development.
- Performs detailed and customized underwriting as primary analyst for all office and industrial acquisitions
- Prepares comprehensive investment summaries with asset and market level analyses for presentation to internal investment committee and institutional investment partners
- Works alongside capital partners, brokers, tenant representatives and prospective investors to analyze new opportunities

LBA Realty – Irvine, CA – 2011
Asset Management Intern

- Assisted in the valuation and management of a $4B portfolio of office and industrial assets

Terranomics Retail Services – Burlingame, CA – 2007 to 2008
Retail Commercial Real Estate Specialist

- Represented Fortune 500 and regional tenants to establish expansion plans, select locations, and negotiate leases in prime retail space
- Managed the leasing of over 2M SF of Power Centers and Grocery anchored shopping center space

Sotheby's International Realty – Santa Barbara, CA – 2006 to 2007
Residential Real Estate Agent

EDUCATION & CREDENTIALS

UC Irvine Merage School of Business, MBA, Real Estate & Finance
UC Santa Barbara, BA, Business & Economics with Emphasis in Accounting

PROFESSIONAL AFFILIATIONS & COMMUNITY INVOLVEMENT

NAIOP – SoCal Chapter
NAIOP – SoCal YPG Alumni
LEED® AP BD+C

Trammell Crow Company

C. Brief History of your firm.

National Experience

Trammell Crow Company (TCC), founded in 1948 in Dallas, Texas, is one of the nation's leading developers and investors in real estate. The company has developed or acquired 2,600 buildings valued at $60 billion and over 565 million square feet. TCC's teams are dedicated to building value for its clients with professionals in 16 major cities throughout the United States. The company serves users of, and investors in office, industrial, retail, healthcare, multi-family residential, mixed use projects, higher education, and airport facilities. For those who occupy real estate, TCC can execute the development or acquisition of facilities tailored to meet its clients' needs. For investor clients, the company specializes in joint venture speculative development, acquisition/re-development ventures, build-to-suit development or providing incentive-based fee development services.

TCC is an independently operated subsidiary of CBRE Group, Inc. (NYSE:CBG), a publicly traded, Fortune 500 and S&P 500 company headquartered in Los Angeles, California. CBRE is the world's largest commercial real estate services and investment firm (in terms of 2016 revenue). For more information visit www.TrammellCrow.com.

Local Expertise

Since TCC's Southern California Development and Investment Group (SoCal D&I) opened in 1972, our team has developed over 100 office, industrial, retail, healthcare, and mixed use projects totaling more than 35 million square feet throughout Los Angeles, Orange, San Bernardino, Riverside, San Joaquin and San Diego Counties. Our Southern California team of 28 professionals is consistently ranked as a "Top Tier" developer and is known for consistently creating the right product in the right market.

Over the past fifteen years, SoCal D&I has built, or is in the process of building, 45 projects comprised of 115 buildings, totaling more than 18 million square feet of office, retail, and industrial product on nearly 1,000 acres of land with costs eclipsing $2.0 Billion. Our team includes in-house environmental expertise through EASI, a division dedicated to managing and mitigating environmental impacts and risks on all new developments. We have worked with numerous cities and municipalities throughout California including, but not limited to Alhambra, Anaheim, Century City, Corona, County of Riverside, Diamond Bar, Fontana, Indio, Irvine, Irwindale, Lake Forest, Los Angeles, Moreno Valley, Pasadena, Redlands, Riverside, and Tracy. Our Team has a proven track record of land acquisitions, ground-leasing, development, planning, construction, leasing, and property management of office buildings. Our experience in each of these areas is demonstrated by the projects outlined herein.

ONE OF THE NATION'S LEADING DEVELOPERS AND INVESTORS IN COMMERCIAL REAL ESTATE

TCC DEVELOPMENT

As of 4Q 2016

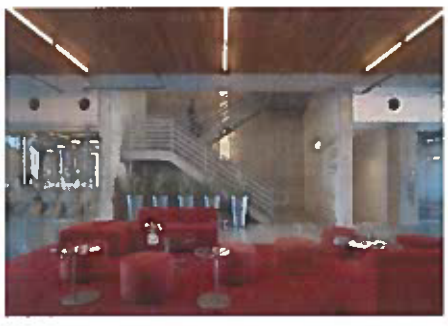
Development in Process	$6.5B
Pipeline	$4.1B
Operating	$0.2B
TOTAL	$10.8B

MERITS

#1 Top Development Firm Commercial Property Executive National 2014, 2015 & 2016

#1 Development Company 2014 & 2015
Modern Healthcare Magazine's Design and Construction Survey

$2.6B in construction starts in 2016



D. Brief description of past experience providing similar services.

The following case studies highlight the TCC SoCal Business Unit's range of experience and expertise across a range of office development product, including speculative, build-to-suit, ground up, and redevelopment.

COUNTY LAW BUILDING - INDIO, CA

PROJECT:	**COUNTY LAW BUILDING**
LOCATION:	Indio, CA
COMPLETION DATE:	December 2014, On Time and Under Budget
REFERENCE:	Stephen Gilbert, Development Manager, Riverside County EDA, (951) 955-4824
PROJECT TYPE:	Class A Office, Governmental Agency Build-to-Suit
SQUARE FOOTAGE:	90,000 SF
PROJECT SUMMARY:	In November 2012, Trammell Crow Company's Southern California Business Unit was selected by the County of Riverside Economic Development Agency as Developer to design, entitle, and construct a state of the art County Law Building in the City of Indio, CA. The new building consolidated multiple County legal departments into a single facility adjacent to the Larsen Courthouse. Located at the prominent corner of Highway 111 and Jackson Street, the Class-A, three story structure creates a focal point at the justice center complex in the midst of its revitalization. The 90,000 SF steel frame building takes advantage of a uniquely shaped site, addressing security and offering multiple access points to separate the public from employee and security oriented vehicle traffic. The building program resulted in the Family Justice Center and the Victim Witness functions occupying 55,000 SF, the Public Defender occupying 24,500 SF, the County Counsel 1,400 SF and the County Law Library 9,450 SF. A future freestanding 5,000 SF retail building will serve the law building and the adjacent community. The project is designed to provide a variety of passive people places both inside and out, including a generous entry plaza complete with an attractive water feature and public art sculpture, shaded outdoor seating and generously landscaped spaces. Through strategic planning, the design team was able to introduce multiple sustainable features including extensive sun shading devices, drought tolerant landscaping, on-site storm drain water retention while recharging the local ground water system, electric vehicle charging stations, photovoltaic parking shade structures, recycled content, low-emitting building materials and many other solutions that have resulted in the project receiving a LEED® Platinum Certification. The project was delivered ahead of schedule and $4M under budget.

GATEWAY AT ALHAMBRA - ALHAMBRA, CA

PROJECT: **GATEWAY AT ALHAMBRA**

LOCATION: Alhambra, CA

COMPLETION DATE: September 2012, On Time and Under Budget

REFERENCE: Jeffrey Siebens, Assistant Director Construction Management, Community Development Commission, County of Los Angeles (626) 586-1792

PROJECT TYPE: Class A Office, Redevelopment, Governmental Agency Build-to-Suit

SQUARE FOOTAGE: 118,265 SF

PROJECT SUMMARY: In August 2010, the Trammell Crow Company's Southern California Business Unit was selected by the National Development Council and the Community Development Commission of the County of Los Angeles (LACDC) as the Developer to design, entitle and construct a state of the art office building for the LACDC. The Gateway at Alhambra was developed in an urban area, where the supply of land is severely constrained. The project development required the demolition of an existing theatre and renovation of an existing parking structure. By selecting a site that could utilize an existing structure, the project was guaranteed sufficient parking, and benefitted from decreased construction time and costs.

The Build-to-Suit office building consolidated two County entities, The Community Development Commission and the Housing Authority, previously located in three separate facilities into a single location. A requirement of the project was to integrate three different and distinct user groups into one building environment. As a redevelopment with an existing parking structure, the building ended up occupying nearly the entirety of the remaining site and the resulting space planning was integrated into a non-typical building site plan.

As a result of extremely efficient design and a collaborative space planning effort by all project constituents, TCC and the project architect were able to reduce the County's original space requirement from 155K SF down to 118K SF, a reduction of nearly 20%, resulting in a significant overall savings in project costs. As part of the project requirements the Community Development Commission required a LEED Silver certification level from the USGBC with the goal of developing a highly sustainable project that would conserve energy, water and non-renewable natural resources while creating a healthier and more comfortable work environment for the Commission and Housing Authority employees. Through strategic planning, the project far exceeded the Community Development Commissions goals as the project ultimately achieved LEED Gold certification.

USC HEALTH SCIENCES BUILDING - LOS ANGELES, CA

PROJECT:	**USC HEALTH SCIENCES BUILDING**
LOCATION:	Los Angeles, CA
COMPLETION DATE:	August 2011, On Time and Under Budget
REFERENCE:	Kristina Raspe, Director, Real Estate and Facilities - Apple, (408) 862-7099
PROJECT TYPE:	Class A Office, Institutional Build-to-Suit
SQUARE FOOTAGE:	120,000 SF
PROJECT SUMMARY:	Trammell Crow Company was selected by the University of Southern California, from a pool of 17 development teams, to ground lease a 5.3 acre property adjacent to the University's Health Science Campus in downtown Los Angeles, create a financing structure to execute the project, and then develop a 120,000 SF administrative office building, which USC would lease back on a concurrent 20 year lease term. To provide USC with a turnkey building, Trammell Crow Company stepped in to manage the programming, design and layout, construction and FF&E delivery of the administrative office, classroom, fitness center and café space. This entailed consolidating 13 different users from all over the USC Los Angeles portfolio into a singular building, while maintaining the specific academic needs of each user group. The project was a resounding success, opening its doors on August 2011 to an onslaught of incoming students ready for their first day of the school year. The project was 4.5 months ahead of USC's required schedule and $2M under budget..

INNOVATION VILLAGE RESEARCH PARK - POMONA, CA

PROJECT:	**INNOVATION VILLAGE RESEARCH PARK AT CAL POLY POMONA**
LOCATION:	Pomona, CA
COMPLETION DATE:	2007, June 2011, December 2015, On Time and Under Budget
REFERENCE:	Sandra Vaughan-Acton, Director of RE Development, Cal Poly Pomona Foundation, Inc. (909) 869-3154
PROJECT TYPE:	Master Planned Class A Office Park, Speculative & Build-to-Suit
SQUARE FOOTAGE:	369,000 SF
PROJECT SUMMARY:	Trammell Crow Company and Cal Poly Pomona University entered into a public/private venture to create a Research Park on its campus. The mission of the partnership was to create an environment in which the business community and the University could interact and collaborate with one another by offering internships to students, job opportunities for graduating students, support of campus programs, etc. TCC and Cal Poly worked together to refine a Master Plan for the remaining 65 acre master planned development with the goal of utilizing additional development opportunities for Build-to-Suits, on-campus academic and student housing facilities. Early in the process it was determined that modern 3-story tilt-up concrete buildings would be the most cost effective construction solution for the product type that was identified to meet the demand in the marketplace. Efficient 40,000 SF floor plates containing a core for each floor with two elevators and adequate restrooms offered flexibility for a wide variety of users, including corporate headquarters, back office, and multi-tenant spaces. The work environment was enhanced by the inclusion of lush landscaping, large people places for relaxation, lunches and outdoor work space, as well as extensive sustainable design features for energy savings, renewable energy, recycled materials, drought tolerant landscaping and water retention resulting in recharging the local groundwater system. Innovation Village Phase 3 commenced as a speculative development by TCC, however Southern California Edison (SCE) was soon identified as a tenant for the entire building. During Phase 3, TCC developed a close partnership with SCE, leading to additional Build-to-Suit opportunities at Innovation Village. In 2009 and again in 2014, TCC was selected as the Developer to design, entitle, and construct Phase 4 and Phase 5 as additional state-of-the-art office buildings to house SCE's Transmission Business Unit.

ARENA CORPORATE CENTER - ANAHEIM, CA

PROJECT:	**ARENA CORPORATE CENTER**
LOCATION:	Anaheim, CA
COMPLETION DATE:	2003, On Time and Under Budget
PROJECT TYPE:	Speculative Class A Office Park
SQUARE FOOTAGE:	385,000 SF
PROJECT SUMMARY:	Arena Corporate Center is a prime example of how TCC's capabilities benefit our clients. Trammell Crow Company purchased 23 acres of land directly adjacent to the Arrowhead Pond in August 2001. The project, comprised of 3 two-story buildings totaling 385,000 square feet, was considered risky by industry experts due to rising vacancy rates, falling rental rates and the languishing recession.

The TCC team recognized that the submarket lacked quality back office space and determined the local tenant base would prefer a campus type environment, a product that was lacking in Central Orange County. Based on these findings, our team scrapped the existing entitled plans and designed 3 two-story buildings with the largest floor plates in the market. The project includes a one-acre palm tree courtyard with electrical and data hookups, outdoor jogging tracks, basketball court and on site showers. Tenants benefit from features such as 1,000 feet of visibility from the 57 freeway, traffic of almost 300,000 cars per day and 5:1 parking.

The project was an immediate success with Tenant Healthcare signing the first lease for 150,000 square feet prior to groundbreaking in March 2002. Construction was completed in June of 2003 and the project was 100% leased at above pro forma rents just 4 months later. Tenants include: Washington Mutual (56,210 SF), Advantage Sales (46,432 SF), Ameriquest (127,750 SF).

THE BOARDWALK - IRVINE, CA

PROJECT:	**THE BOARDWALK**
LOCATION:	Irvine, CA
COMPLETION DATE:	Projected Completion Summer 2017, Currently On Time & On Budget
PROJECT TYPE:	Class A Speculative Office Campus
SQUARE FOOTAGE:	545,385 SF
PROJECT SUMMARY:	Located on Orange County's most traveled thoroughfare, this 7.5 acre project will be comprised of two, nine-story towers totaling approximately 545,000 square feet of best-in-class office space, two acres of landscaped outdoor space, and abundant on-site amenities. Designed by world renowned architect Gensler, The Boardwalk is poised to revolutionize the Orange County workplace through a perfect blend of form and function, delivering not only iconic architecture and a picturesque landscape, but a design that promotes productivity, efficiency, wellness, and a coastal lifestyle. The buildings offer large floor plates, connected on alternating floors with indoor bridges and outdoor terraces. By bridging the two buildings, The Boardwalk provides the opportunity for up to 65,000 square feet of contiguous space on a single floor, offering unmatched connectivity and efficiency, and office and amenity space unlike anything else in the market. This cutting edge design will enhance productivity by promoting collaboration and demonstrate a creative culture. The Boardwalk offers a comprehensive amenity package including indoor and outdoor workspace, on-site fitness and wellness center, and on-site dining options to provide a well-rounded lifestyle for its occupants. The project is currently under construction, with completion scheduled for Summer of 2017. Leasing is underway, with multiple leases and LOI's currently being negotiated with potential to account for over 400,000 SF of space.

RIVERSIDE UNIVERSITY HEALTH SYSTEM MOB - MORENO VALLEY, CA

PROJECT: **RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL OFFICE BUILDING**

LOCATION: Moreno Valley, CA

COMPLETION DATE: Projected Completion 4Q 2019

PROJECT TYPE: Master Planned Development, Phase 1: Class A Build-to Suit Medical Office Building

SQUARE FOOTAGE: 200,000 SF

PROJECT SUMMARY: In April 2015, Trammell Crow Company's Southern California Business Unit was selected as the Master Developer and Owner to plan, design, entitle and construct a state of the art medical office building for the County of Riverside Economic Development Agency and the Riverside University Health System Medical Center. The new building would be located within the existing parking field of the Medical Center and would provide ambulatory care services and ancillary functions for the hospital.

TCC was requested to provide a 200,000 SF MOB located directly in front of the main entrance to the hospital from Cactus Avenue. The building was sited in a manner that allows for connectivity to the existing Education Building & parking fields, as well as future integration into the hospital campus and a proposed parking structure to the east. The location of the building required the re-location of the main entry drive further from the current southern location to the west and creating a new 8,000 SF Lobby/Café building with a connected canopy structure to bring visitors and patients in from the west side of the hospital. Services provided include multi-specialty clinics, outpatient surgery, and physical therapy programs.

After evaluating various financing structures, it was determined that the MOB would be constructed with funds secured through a Credit Tenant Lease (CTL). CTL loans are credit-based debt instruments that provide fully amortizing loans that are coterminous with a tenant's lease. This unique and extremely complex financing vehicle provides tenants with investment grade credit, the ability to finance the entire cost of a new facility through a "rent-to-own" structure. CTL financing offers options for both monetizing existing assets and capitalizing build to suits.

In April 2017, TCC successfully completed entitlements, finalized negotiations on the ground lease and facilities lease, and secured the CTL loan for the County of Riverside. Construction of the 200,000 SF MOB facility is slated to commence later this year, with completion projected for 4Q 2019.

SECTION 2. ADDITIONAL QUESTIONS

A. PROVIDE ANY COMMENTS, OBSERVATIONS OR SUGGESTIONS WHICH MAY ASSIST CALOPTIMA IN DRAFTING A PROCUREMENT SOLICITATION.

TCC has vast experience working with numerous public agencies throughout the RFP and ultimately the development process. As a result, some of the fundamental elements that we have identified and recommend which will allow for the smoothest and most efficient procurement process include:

1. Provide a central point of contact for the decision making team. A clear line of communication will simplify and expedite the procurement and negotiation process.

2. Be prepared with a streamlined decision making process. As outlined below, the entire development process will take two or more years to complete. In order to capitalize on the in-place entitlements and current market demand, CalOptima and the new buyer will need to ready to move quickly and efficiently.

3. If possible, be prepared to further define CalOptima's future space requirements prior to issuance of the RFP. Quantifying the square footage required reduces risk by providing greater certainty for the developer and could expedite the overall development process.

4. Evaluate the overall quality of the developer as part of the offer. In addition to the basic terms of the proposal, CalOptima's consideration should include not only track record, experience, and capitalization, but also the reputation and culture. At a minimum, CalOptima will be neighboring the new building, and could potentially occupy space in the new project. As such, a collaborative buyer and potential partner will be a critical element in the next phase of the project.

B. PLEASE PROVIDE A BRIEF SUMMARY OF HOW YOU MIGHT ENVISION THE TRANSACTION STRUCTURES THAT YOUR FIRM WOULD PROPOSE.

As outlined in the above case studies, TCC has the capability to finance and develop premier office space under various deal structures and can offer a range of financing structures. Our team is equally well suited for traditional joint venture relationships with institutional capital partners, as well as collaborative partnerships with governmental and public agencies. We have substantial experience with and are open to various deal structures. While each arrangement is ultimately market driven, we focus on how we can assist and deliver results to our clients.

1. **Direct Fee Purchase: CalOptima may consider a direct fee purchase of the Excess Land and associated entitlements. Respondent's proposal for this approach must include estimates of proposed purchase price, transaction timing, and other general provisions of Respondent's proposal.**

   While TCC anticipates fair market value for the land and associated entitlements, additional aspects of the project would need to be further understood before pricing could be determined. TCC is highly interested and prepared to pursue this asset, but will require additional information relating to status of entitlements, CC&R's, off-sites, subdivision process, reciprocal parking agreements, exactions, and plan check and permit fees. Additionally, CalOptima's future requirements for space or options on space could have an impact on what would be determined to be fair market value.

2. **Ground Lease/Participating Ground Lease: CalOptima may consider a ground lease of the Excess Land. In the case of a ground lease, or participating ground lease proposal, the Offeror should include an estimated initial base rent, lease term and lease payment commencement, proposed escalation, ground lease term, subordination (an unsubordinated ground lease is strongly preferred), and other general terms of the ground lease/participating ground lease. In the event Offeror proposes a participating ground lease, Offeror's proposal should include minimum rent, percentage participating, formula and basis for participation as well as the other terms addressed in the fixed ground lease proposal.**

   While Trammell Crow Company's Newport Beach Business Unit has extensive experience with ground leases, it is not our preferred deal structure. However, we have a thorough understanding of the process, including the unique nuances of underwriting and structuring of ground lease documents. In the eyes of the ownership and investment community, the ground lease is generally considered to be an inferior structure to fee simple ownership. As such, the terms of the ground lease would need to reflect this discount in valuation.

Under a ground lease scenario, the rent or rate of return to CalOptima as the ground lessor will be largely dependent upon the requirement as a tenant. In order to appropriately propose pricing, TCC will need to further understand whether the existing building would be included, and if so, the physical condition and CalOptima's intended occupancy duration of the existing building, as well as any potential future space and timing needs within the new building.

3. **Joint Venture: While a joint venture between a private-sector entity and a public agency does present its challenges, CalOptima wants to remain flexible with regard to potential transaction structures that may enhance cash flow, flexibility and overall economic benefit for the agency. Respondents proposing a joint venture structure should address joint venture structure preferential rates of return, capital contribution values, distribution priorities and capital risk exposure. Please keep in mind that CalOptima will require that its equity value be in first priority and not subject to foreclosure risk.**

   TCC has completed Joint Ventures in various forms with public and governmental agencies, as well as traditional partnerships with institutional investors. In order to best structure an agreement with any partner, in depth conversations must take place in order to communicate, understand, and agree upon an overall investment strategy. In order to propose the most appropriate deal structure, TCC would request the opportunity to discuss CalOptima's appetite for risk, return expectations, equity and debt contributions, investment duration, and potential occupancy needs within the to-be-built building.

   By determining CalOptima's future needs, TCC can establish a clear and strategic go forward strategy that will maximize the value of the property, as well as provide or arrange for a variety of financing vehicles which will provide ultimate flexibility for both parties.

4. **Potential Trade: As part of its mandated healthcare delivery mission for the residents of Orange County, CalOptima anticipates that its staffing levels may continue to increase over the coming years. While CalOptima does not occupy all of the current building, it anticipates that as a space in the building is recaptured, its space needs may exceed the capacity of the current building. As such, acquisition of a nearby, preferably, adjacent building may be of interest to CalOptima. Respondents that currently own a nearby building may want to consider proposing a trade of the Excess Land for such a building. Respondents considering this approach should address: the location and physical condition of the trade property, any existing leases or other restrictions on occupancy, building condition, and terms of trade.**

   TCC is open to exploring trade opportunities following further discussion and understanding of CalOptima's needs and requirements.

C. If possible, please provide preliminary economic results of how you might see a transaction being structured.

As previously discussed, TCC is open to and will entertain various types of structures. However, returns will be predicated upon market forces, as well as a number of economic factors which will need to be further discussed as a partnership or buyer/seller relationship progresses. As a potential occupant of the to-be-built building, the needs of CalOptima will be a primary driver in how best to structure a deal and potential profitability. TCC brings substantial experience and expertise in the development process, as well as deal structure creativity and capital relationships which provide for ultimate flexibility in delivering a variety of finance vehicles, including traditional equity and debt joint ventures, tax exempt bond financing, Credit Tenant Leases (CTL), or synthetic leases, among others. TCC will be better suited to address profitability for both parties after assessing CalOptima's needs as both a tenant and investor.

D. Please provide a potential timeline for any of the structures that you believe might be appropriate for your firm.

Following the April 21st receipt of the RFI responses CalOptima will need to read, evaluate, and interview the respondents. By allowing 30 to 45 days for that process, TCC would estimate a June 2017 commencement and the following approximate timelines if an RFP was deemed necessary.

a) RFP – 60 to 90 days
b) PSA / JV document – 30 days
c) Escrow – 60 to 90 days
d) Design – 10 to 12 months
e) Construction – 14 to 18 months
f) Lease Up of non-CalOptima space – TBD subject to determining CalOptima expansion requirement – 0 to 24 months

E. Please outline the obligations that your firm would request of CalOptima as part of any transaction structure.

As a potential partner or purchaser of the property, TCC would request from CalOptima, the following obligation and information:

- Exclusive right to negotiate
- Further understanding of CalOptima's timing expectations for identifying future expansion needs
- Further understanding of CalOptima's preferred deal structure
- Further understanding of CalOptima's experience and history as both a Joint Venture Partner or Ground Lessor

TESTIMONIALS

Trammell Crow Company

amazon

"Trammell Crow Company's teamwork atmosphere and leadership in the development process has led to a highly successful project for all parties concerned."

"Trammell Crow Company is a great partner, and we look forward to continuing our relationship."

"Their expertise in development management and their knowledge of the university's and the state's approval process greatly aided the project team in successfully completing these two projects in a timely manner; allowing SCE to move personnel into the facilities ahead of all expectations. Their guidance and counsel to the project team was invaluable. All personnel associated with the project were both helpful and professional in all aspects."

SOUTHERN CALIFORNIA EDISON®

An EDISON INTERNATIONAL® Company

City of Alhambra

"Trammell Crow Company team leadership capabilities and knowledge of development has created an effective relationship with City Staff and a proactive approach to the development which has yielded an outstanding project that will enhance the City Central Business District for years to come. Trammell Crow Company continues to be a reliable partner, one that meets their obligations and commitments to the community."

"The Cal Poly Pomona Foundation highly recommends the Trammell Crow Company as a developer. We are very pleased to be partnering with them now, and we look forward to future partnerships."

Cal Poly Pomona Foundation

COUNTY OF LOS ANGELES CALIFORNIA

"The Community Development Commission of the County of Los Angeles wishes to express its appreciation to the Trammell Crow Company... "

"Trammell Crow Company's excellence as a developer is second to none. The firm meets its commitments."

Trammell Crow Company

3501 Jamboree Road, Suite 230
Newport Beach, CA 92660
(949) 477-4700

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State of California

WELFARE AND INSTITUTIONS CODE

Section 14087.54

14087.54. (a) Any county or counties may establish a special commission in order to meet the problems of the delivery of publicly assisted medical care in the county or counties and to demonstrate ways of promoting quality care and cost efficiency.

(b) (1) A county board of supervisors may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter. The boards of supervisors of more than one county may also establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. If a board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to "county" shall mean a commission established pursuant to this section.

(2) A commission operating pursuant to this section may also enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits under any publicly supported program, if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs. The commission shall not use any payments or reserves from the Medi-Cal program for this purpose.

(3) In addition to the authority specified in paragraph (1), the board of supervisors may, by ordinance, authorize the commission established pursuant to this section to provide health care delivery systems for any or all of the following persons:

(A) Persons who are eligible to receive medical benefits under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395).

(C) Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The commission shall not use any payment or reserve from the Medi-Cal program for purposes of this subparagraph.

(4) Nothing in this section shall prohibit a commission established pursuant to this section from providing services pursuant to subparagraph (C) of paragraph (3) in counties other than the commission's county if the commission is approved by the Department of Managed Health Care to provide services in those counties. The

commission shall not use any payment or reserve from the Medi-Cal program for purposes of this paragraph.

(5) For purposes of providing services to persons described in subparagraph (A) or (B) of paragraph (3), if the commission seeks a contract with the federal Centers for Medicare and Medicaid Services to provide Medicare services as a Medicare Advantage program, the commission shall first obtain a license under the Knox-Keene Health Care Service Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(6) With respect to the provision of services for persons described in subparagraph (A) or (B) of paragraph (3), the commission shall conform to applicable state licensing and freedom of choice requirements as directed by the federal Centers for Medicare and Medicaid Services.

(7) Any material, provided to a person described in subparagraph (A) or (B) of paragraph (3) who is dually eligible to receive medical benefits under both the Medi-Cal program and the Medicare Program, regarding the enrollment or availability of enrollment in Medicare services established by the commission shall include notice of all of the following information in the following format:

(A) Medi-Cal eligibility will not be lost or otherwise affected if the person does not enroll in the plan for Medicare benefits.

(B) The person is not required to enroll in the Medicare plan to be eligible for Medicare benefits.

(C) The person may have other choices for Medicare coverage and for further assistance may contact the federal Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or www.Medicare.gov.

(D) The notice shall be in plain language, prominently displayed, and translated into any language other than English that the commission is required to use in communicating with Medi-Cal beneficiaries.

(c) It is the intent of the Legislature that if a county forms a commission pursuant to this section, the county shall, with respect to its medical facilities and programs occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as a board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered an entity separate from the county or counties, shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and shall file the statement required by Section 53051 of the Government Code. The commission shall have in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section

6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(e) Upon creation, a commission may borrow from the county or counties, and the county or counties may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event a commission may no longer function for the purposes for which it was established, at the time that the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board or boards of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of a commission, the board or boards of supervisors shall notify the State Department of Health Care Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board or boards within 10 days of completion of the audit. The board or boards shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of a commission by the board or boards, the county or counties shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county or counties upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of a commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

(j) Nothing in this section shall be construed to supersede Section 14093.06 or 14094.3.

(Amended by Stats. 2007, Ch. 483, Sec. 51. Effective January 1, 2008.)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
7. Consider Approval of Proposed Revisions to CalOptima's Operations Policies and Procedures

Contacts
Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Belinda Abeyta, Executive Director, Operations (657)-235-6755

Recommended Actions:
1. Approve modification of the following policies and procedures in connection with CalOptima's regular review process:
   a. DD.2013: Customer Service Grievance Process
   b. FF.2003: Coordination of Benefits
   c. FF.2005: Conlan, Member Reimbursement
   d. FF.2011: Direct Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services
   e. FF.2012: Direct Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services
   f. MA.3101: Claims Processing

2. Authorize Staff to further update Attachment A of Policies FF.2011 and FF.2012 for the continuation of payment of Directed Payments to eligible non-contracted providers for qualifying non-contracted Ground Emergency Medical Transport (GEMT) services for State Fiscal Year (SFY) 2020-2021 with dates of service between July 1, 2020 and June 30, 2021, upon receipt of and pursuant to DHCS's written instruction to CalOptima prior to the release of DHCS final guidance, with any further changes to Attachment A remaining subject to Board approval.

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

Modification to CalOptima Policies. Proposed policy modifications are summarized below:

1. ***DD.2013: Customer Service Grievance Process*** defines the criteria by which a CalOptima's Customer Service department intakes, addresses, resolves, and tracks grievances from a member, a member's authorized representative or a provider acting on behalf of a member, in accordance with applicable statutory, regulatory, and contractual requirements. CalOptima staff recommends revising the policy to ensure its alignment with current operational processes and regulatory requirements. Proposed revisions include distinguishing a "grievance" from an "inquiry" and modifications of definitions.

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2. ***FF.2003: Coordination of Benefits*** defines the criteria by which CalOptima's Claims Administration Department determines Coordination of Benefits (COB), or order of payment, for payment of covered services when a member has active coverage by more than one group health plan. CalOptima staff proposes revising this policy pursuant to the CalOptima annual review process to ensure alignment with current operational systems and regulatory requirements of the Department of Health Care Services (DHCS) *All Plan Letter (APL) 20-010: Cost Avoidance and Post-Payment Recovery for Other Health Coverage*. Recommended revisions include ensuring with current operational processes and regulatory requirements, including revision of definitions and adding procedural changes consistent with *DHCS All Plan Letter (APL) 20-010: Cost Avoidance and Post-Payment Recovery for Other Health Coverage*.

3. ***FF.2005: Conlan, Member Reimbursement*** defines the criteria by which CalOptima's Claims Administration Department complies with DHCS *Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process*, the court-ordered reimbursement process to members for paid out-of-pocket expenses for Medi-Cal covered services. CalOptima staff recommends revising the policy to ensure its alignment with current operational processes and regulatory requirements. Proposed revisions include modifications to definitions and removing references to CalOptima Policy *GG.1413: Polypharmacy Management* and CalOptima Policy *GG.1416: Pharmacy Home Program* as these policies are no longer applicable to policy *FF.2005: Conlan, Member Reimbursement* with DHCS transition of pharmacy benefits for Medi-Cal members to Medi-Cal Rx carve-out effective January 1, 2021.

4. ***FF.2011: Direct Payments for Qualifying Services Rendered to CalOptima Health Network Member When Health Networks are Financially Responsible for the Qualifying Services*** defines the criteria by which Health Networks comply with the DHCS Direct Payment program guidance. CalOptima staff recommends revising the policy to ensure alignment with current operational processes and regulatory requirements. Proposed revisions include modifications to definitions, the addition of regulatory requirements as stated in DHCS *All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services*, and DHCS *All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments* updates to Attachment A: Direct Payments Rates and Codes to include Proposition 56: Family Planning Services and Proposition 56: Valued-Based Payment (VBP) Program Services, and the addition of new Attachment B: VBP Program Specifications: Value-Based Payment Program Performance Measures 2020.

5. ***FF.2012: Direct Payments for Qualifying Services Rendered to CalOptima Direct or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services*** defines the criteria by which CalOptima will comply with the DHCS Direct Payment program guidance. CalOptima staff recommends revising the policy to ensure alignment with current operational processes and regulatory requirements. Proposed revisions include modifications to definitions, addition of regulatory requirements as stated in DHCS *All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services*, and DHCS *All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments* updates to Attachment A: Direct Payments Rates and Codes to include Proposition 56: Family Planning Services and Proposition 56: Valued-Based Payment (VBP) Program Services, and the

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addition of new Attachment B: VBP Program Specifications: Value-Based Payment Program Performance Measures 2020.

6. ***MA.3101: Claims Processing*** defines the criteria by which CalOptima's Claims Administration Department ensures the timely and accurate processing and adjudication of claims by CalOptima or a health network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR). CalOptima staff recommends revising the policy to ensure its alignment with current operational processes and regulatory requirements. Proposed revisions include notifications to definitions and adding requirements for reopening and revision of claim determinations as required under *Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revisions of Claim Determinations and Decisions*.

Directed Payments for GEMT Services (SFY 2020-2021). CalOptima Policies FF.2011 and FF.2012 include directed payments to eligible non-contracted providers for qualifying non-contracted Ground Emergency Medical Transport (GEMT) services for State Fiscal Years (SFYs) 2018-19 and 2019-20. On October 15, 2020, the Centers for Medicare & Medicaid Services (CMS) approved the State Plan Amendment (SPA) 20-0009 for the continuation of directed payments for GEMT services for SFY 2020-21 with dates of service between July 1, 2020 and June 30, 2021. The approved SPA includes directed payment rates and codes that are the same as the preceding SFY 2019-2020. However, DHCS has not yet released the final All Plan Letter for SFY 2020-21, which, based on prior experience, could take approximately four months from the date of the approved SPA. Staff is seeking written instruction from DHCS on whether to continue to pay the directed payments for such GEMT services prior to the release of the final APL and, therefore, is requesting the Board for authority to update Attachment A: Directed Payments Rates and Codes (Attachment A) of CalOptima Policies FF.2011 and FF.2012 upon receipt of and pursuant to DHCS written instruction.

Staff's request for authority, as described above, is limited and does not extend to directed payments for GEMT services for subsequent SFYs or any other Directed Payment programs.
Any further changes to Attachment A of Policy FF.2012 are subject to Board approval. While the Board previously authorized the Chief Executive Officer to update and amend Attachment A of Policy FF.2011 pursuant to DHCS final guidance or written instruction to CalOptima, in order to align with the approach for Policy FF.2012, staff proposes that any further changes to Attachment A of Policy FF.2011 will also be subject to Board approval.

Fiscal Impact
The recommended action to revise CalOptima Policies DD.2013, FF.2003, FF.2005 and MA.3101 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

The recommended action to revise Attachment A: Directed Payments Rates and Codes of CalOptima Policies FF.2011 and FF.2012 is 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. All other revisions to CalOptima Policies FF.2011 and FF.2012 are operational in nature and has no additional fiscal impact

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beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

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

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

Attachments

1. DD.2013: Customer Service Grievance Process
2. FF.2003: Coordination of Benefits
3. FF.2005: Conlan, Member Reimbursement
4. FF.2011: Direct Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services
5. FF.2012: Direct Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services
6. MA.3101: Claims Processing
7. DHCS All Plan Letter (APL) 20-010: Cost Avoidance and Post-Payment Recovery for Other Health Coverage
8. DHCS All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement
9. DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
10. DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments
11. DHCS California State Plan Amendment (SPA) CA-20-0009
12. Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Direct Payments Policy
13. Board Action dated June 4, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy and Modifications to Claims Administration Policies and Procedures

/s/ Richard Sanchez — *11/24/2020*
Authorized Signature — **Date**

Policy:	DD.2013
Title:	~~Exempt~~Customer Service Grievance Process
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	12/01/2016
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process by which the CalOptima Customer Service Department intakes, addresses, resolves, and tracks ~~an Exempt Grievance~~Grievances from a Member, ~~or~~ a Member's Authorized Representative, or a Provider acting on behalf of a Member, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima and its contracted Health Networks shall establish and maintain a Grievance process to intake, triage, and address a Member's, a Member's Authorized Representative, or Provider acting on behalf of the Member, expression of dissatisfaction and/or a request to file a Grievance for review and Resolution.

B. CalOptima and its contracted Health Networks Grievance process shall distinguish an "Inquiry," which is a request for information that does not include an expression of dissatisfaction, from a Grievance which is a written or oral expression of dissatisfaction about any matter other than an Adverse Benefit Determination pursuant to Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

~~A.~~C. Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day~~,~~ are exempt from the requirement from sending a written acknowledgment and response and shall be classified as an Exempt Grievance.

~~B. CalOptima shall establish and maintain an Exempt Grievance process by which a Member, or a Member's Authorized Representative, or a provider acting on behalf of a Member, may express discontent or dissatisfaction for resolution.~~

~~C. CalOptima's Exempt Grievance process shall address the MemberMember's Authorized Representative's, or a provider's, acting on behalf of a Member, dissatisfaction or discontent in accordance with applicable statutory, regulatory, and contractual requirements.~~

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D. CalOptima and its contracted Health Networks shall refer all potential medical quality of care issues identified through the ~~Exempt~~Customer Service Grievance process to the CalOptima Grievance and Appeals Resolution Service (GARS) Department for action. GARS' actions may include, ~~including~~ but are not limited to, referral to the CalOptima Quality Improvement Department for review, in accordance with CalOptima Policy HH.1102: Member Grievance.

E. CalOptima and its contracted Health Networks shall inform a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, of ~~their~~the right to file a Grievance through CalOptima at ~~anytime~~any time, in accordance with Title 42 of the Code of Federal Regulations, Section 438.402(c)(2)(i).

F. ~~CalOptima shall maintain written records and log of each~~CalOptima and its contracted Health Networks shall not discourage the filing of Grievances. A Member, Member's Authorized Representative, or a Provider acting on behalf of a Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance.

~~F.~~G. CalOptima and its contracted Health Networks shall maintain records and logs of each standard and Exempt Grievance, including the date of receipt, name of complainant, Member's name and client identification number (CIN), nature of the ~~Exempt~~ Grievance, names of the CalOptima staff who received the ~~Exempt~~ Grievance, and name of the CalOptima staff who resolved the ~~Exempt~~ Grievance and ensure ~~Exempt~~ Grievances are included in the aggregated Grievance data reported to the Department of Health Care Services (DHCS).

~~G.~~H. CalOptima and its contracted Health Networks shall ensure that there is no discrimination against a Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member on the grounds that the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member filed ~~an Exempta~~ Grievance~~, in accordance with Section III.C. of this policy~~.

III. PROCEDURE

~~A. Exempt Grievance Process~~

A. Inquiry

1. If a ~~A~~ Member, a Member's Authorized Representative, or a ~~provider~~Provider acting on behalf of a Member, contacts the Customer Service Department, by telephone or in-person, and ~~may express~~can requests information pertaining to eligibility, benefits, or other CalOptima processes with no expression of dissatisfaction, it is an Inquiry, rather than a Grievance.~~, or discontent, to CalOptima's~~the ~~Customer Service Department by telephone, or in person.~~

2. CalOptima's Customer Service staff shall:

a. Identify and document the ~~cause~~nature of the ~~Member, Member's Authorized Representative's, or provider's, acting on behalf of a Member, dissatisfaction; Educate~~Inquiry given by the Member, Member's Authorized Representative, or ~~a provider~~Provider acting on behalf of a Member;

b. Categorize the Inquiry with the appropriate subject and category codes;

c. Provide the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member~~, on their right~~ with the requested information; and

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d. Close the Inquiry with the appropriate disposition codes.

B. Standard Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, can request to file a grievance to the Customer Service Department by telephone, or in person.

2. CalOptima's Customer Service staff shall:

a. Identify and document the nature of the Grievance given by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Inform the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member of the Resolution timeframes;

c. Mark the grievance with the appropriate Priority Code (routine or urgent); and

~~a.~~d. Route the Grievance to the GARS Department. The GARS Department shall process the Grievance in accordance with CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint;~~Grievance.

3. ~~Determine if they are able to provide a resolution to the Member's~~The Customer Service Department shall continue to assist the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member with any additional or immediate needs.

C. Exempt Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, may express dissatisfaction, or discontent, to CalOptima's Customer Service Department by telephone, or in person.

2. The Customer Service Department staff shall:

a. Identify and document the nature of the dissatisfaction ~~or discontent by~~expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Document all actions taken to address the dissatisfaction expressed by the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member, as well as the Resolution provided in response to the dissatisfaction expressed by the Member~~'s~~, Member's Authorized Representative, or Provider acting on behalf of the Member; and

~~a.~~c. If the Grievance is resolved by the close of the ~~following~~next business day~~;~~, close the Grievance with the appropriate disposition codes.

~~2.~~3. ~~Clearly document~~If Customer Service Department staff is unable to provide Resolution to the Member, a Member's Authorized Representative, or ~~a provider's,~~Provider acting on behalf of a Member, dissatisfaction or discontent~~, as well as the resolution provided in response to the Member's, Authorized Representative's, or provider's contact;~~ by close of the next business day, CalOptima's Customer Service staff shall:

a. ~~Flag~~Educate the Member, a Member's Authorized Representative, or a ~~provider's~~Provider acting on behalf of a Member, ~~dissatisfaction for reporting purposes; Provide language~~

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~~assistance for Threshold Languages and language line interpretation services, as needed, to register and resolve the Exempt~~ of Grievance~~; and Make one (1) attempt to call the~~ rights, in accordance with CalOptima Policy HH.1102: CalOptima Member ~~back if the call is disconnected while~~Complaint, and inform the issue(s) will be referred to the GARS Department;

b. Inform the Member, a Member's Authorized Representative, or a ~~provider~~Provider acting on behalf of a Member ~~expresses dissatisfaction during~~of the Resolution timeframes; and

~~a.~~c. If the ~~call~~Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member agrees to refer the Grievance, route grievance to the GARS Department.

4. If the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member expressly declines to file the Grievance, Customer Service staff shall:

a. Categorize the issue as a Grievance;

b. Continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member until the Grievance is fully resolved; and

c. Close the Grievance with the "Declined Grievance/Resolved" disposition code.

~~B.~~D. Records and Reports

1. ~~CalOptima's~~The Customer Service Department staff shall log the call into the core business system to document receipt of the ~~Exempt~~ Grievance, the disposition and ~~the resolution~~Resolution provided to the Member, Member's Authorized Representative, or a ~~provider~~Provider acting on behalf of a Member.

2. ~~CalOptima's~~The Customer Service Department shall maintain a ~~report of~~record in the core business system for each standard and Exempt Grievance, including the date of receipt, Member's name and client identification number (CIN), nature of the ~~Exempt~~ Grievance, the ~~resolution~~Resolution provided, and the Customer Service Representative's name who took the call and resolved the Exempt Grievance.

3. ~~CalOptima's~~The Customer Service Department shall ~~maintain a report of each Exempt~~, on a monthly basis, provide a "Declined Grievance ~~flagged as a quality of care concern, which is~~/Resolved" report to GARS to be ~~forwarded to the CalOptima Quality Improvement Department~~ aggregated for ~~further investigation upon completion of the call, or visit. Customer Service Department Managers~~tracking and ~~Directors~~trending purposes as with other Grievances.

~~3.~~4. The Customer Service and GARS Department management staff shall, on a monthly ~~and quarterly~~ basis, review reports for tracking and trending of ~~Exempts~~Exempt Grievances by Provider, Health Network, and Grievance category.

~~4.~~5. The Customer Service Department shall ensure Exempt Grievances are incorporated in the quarterly Grievance and Appeals Report.

~~C. CalOptima and its contracted Health Networks shall not discriminate or retaliate against any Member on grounds that such Member filed an Exempt Grievance, in accordance with CalOptima Policy HH.3012A: Non-Retaliation for Reporting Violations.~~

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance
D. CalOptima Policy HH.1103: ~~CalOptima~~ Health Network Member ~~Complaint~~Grievance and Appeal Process
~~E. CalOptima Policy HH.3012A: Non-Retaliation for Reporting Violations~~
~~F.~~E. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~G. Health and Safety Code, §1368(a)(4)(B)~~
~~H.~~F. Title ~~28, California~~42 Code of Federal Regulations (C.~~CF~~.R~~), §1300.68(d)(8) .~~), § 438.402(c)(2)(i)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
06/21/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	06/01/2017	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	10/01/2018	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	TBD	DD.2013	Customer Service Grievance Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors ~~and as further described in CalOptima Policy HH.3009.~~
Complaint	A complaint is the same as a Grievance. Where the Customer Service staff is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Exempt Grievance	Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response.
Grievance	~~An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.~~ A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by CalOptima to make an authorization decision.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
~~Inquiry~~	A request for information that does not include an expression of dissatisfaction. Inquiries may include, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima processes.
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.

Term	Definition
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.
Resolution	~~The state at which a grievance or exempt~~The grievance has reached a final conclusion with respect to the ~~Member or Provider's~~ submitted ~~grievance~~Grievance.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the ~~Group~~Population Needs Assessment (~~GNA~~PNA).

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Policy:	DD.2013
Title:	**Customer Service Grievance Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	12/01/2016
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process by which the CalOptima Customer Service Department intakes, addresses, resolves, and tracks Grievances from a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima and its contracted Health Networks shall establish and maintain a Grievance process to intake, triage, and address a Member's, a Member's Authorized Representative, or Provider acting on behalf of the Member, expression of dissatisfaction and/or a request to file a Grievance for review and Resolution.

B. CalOptima and its contracted Health Networks Grievance process shall distinguish an "Inquiry," which is a request for information that does not include an expression of dissatisfaction, from a Grievance which is a written or oral expression of dissatisfaction about any matter other than an Adverse Benefit Determination pursuant to Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

C. Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day are exempt from the requirement from sending a written acknowledgment and response and shall be classified as an Exempt Grievance.

D. CalOptima and its contracted Health Networks shall refer all potential medical quality of care issues identified through the Customer Service Grievance process to the CalOptima Grievance and Appeals Resolution Service (GARS) Department for action. GARS' actions may include, but are not limited to, referral to the CalOptima Quality Improvement Department for review, in accordance with CalOptima Policy HH.1102: Member Grievance.

E. CalOptima and its contracted Health Networks shall inform a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, of the right to file a Grievance through

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CalOptima at any time, in accordance with Title 42 of the Code of Federal Regulations, Section 438.402(c)(2)(i).

F. CalOptima and its contracted Health Networks shall not discourage the filing of Grievances. A Member, Member's Authorized Representative, or a Provider acting on behalf of a Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance.

G. CalOptima and its contracted Health Networks shall maintain records and logs of each standard and Exempt Grievance, including the date of receipt, name of complainant, Member's name and client identification number (CIN), nature of the Grievance, names of the CalOptima staff who received the Grievance, and name of the CalOptima staff who resolved the Grievance and ensure Grievances are included in the aggregated Grievance data reported to the Department of Health Care Services (DHCS).

H. CalOptima and its contracted Health Networks shall ensure that there is no discrimination against a Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member on the grounds that the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member filed a Grievance.

III. PROCEDURE

A. Inquiry

1. If a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, contacts the Customer Service Department, by telephone or in-person, and requests information pertaining to eligibility, benefits, or other CalOptima processes with no expression of dissatisfaction, it is an Inquiry, rather than a Grievance.

2. CalOptima's Customer Service staff shall:

   a. Identify and document the nature of the Inquiry given by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

   b. Categorize the Inquiry with the appropriate subject and category codes;

   c. Provide the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member with the requested information; and

   d. Close the Inquiry with the appropriate disposition codes.

B. Standard Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, can request to file a grievance to the Customer Service Department by telephone, or in person.

2. CalOptima's Customer Service staff shall:

   a. Identify and document the nature of the Grievance given by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Inform the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member of the Resolution timeframes;

c. Mark the grievance with the appropriate Priority Code (routine or urgent); and

d. Route the Grievance to the GARS Department. The GARS Department shall process the Grievance in accordance with CalOptima Policy HH.1102: Member Grievance.

3. The Customer Service Department shall continue to assist the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member with any additional or immediate needs.

C. Exempt Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, may express dissatisfaction, or discontent, to CalOptima's Customer Service Department by telephone, or in person.

2. The Customer Service Department staff shall:

a. Identify and document the nature of the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Document all actions taken to address the dissatisfaction expressed by the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member, as well as the Resolution provided in response to the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of the Member; and

c. If the Grievance is resolved by the close of the next business day, close the Grievance with the appropriate disposition codes.

3. If Customer Service Department staff is unable to provide Resolution to the Member, a Member's Authorized Representative, or Provider acting on behalf of a Member, dissatisfaction or discontent by close of the next business day, CalOptima's Customer Service staff shall:

a. Educate the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, of Grievance rights, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint, and inform the issue(s) will be referred to the GARS Department;

b. Inform the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member of the Resolution timeframes; and

c. If the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member agrees to refer the Grievance, route grievance to the GARS Department.

4. If the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member expressly declines to file the Grievance, Customer Service staff shall:

a. Categorize the issue as a Grievance;

b. Continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member until the Grievance is fully resolved; and

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c. Close the Grievance with the "Declined Grievance/Resolved" disposition code.

D. Records and Reports

1. The Customer Service Department staff shall log the call into the core business system to document receipt of the Grievance, the disposition and Resolution provided to the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member.

2. The Customer Service Department shall maintain a record in the core business system for each standard and Exempt Grievance, including the date of receipt, Member's name and client identification number (CIN), nature of the Grievance, the Resolution provided, and the Customer Service Representative's name who took the call and resolved the Exempt Grievance.

3. The Customer Service Department shall, on a monthly basis, provide a "Declined Grievance/Resolved" report to GARS to be aggregated for tracking and trending purposes as with other Grievances.

4. The Customer Service and GARS Department management staff shall, on a monthly basis, review reports for tracking and trending of Exempt Grievances by Provider, Health Network, and Grievance category.

5. The Customer Service Department shall ensure Exempt Grievances are incorporated in the quarterly Grievance and Appeals Report.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy HH.1102: Member Grievance
D. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
F. Title 42 Code of Federal Regulations (C.F.R.), § 438.402(c)(2)(i)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
06/21/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	06/01/2017	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	10/01/2018	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	TBD	DD.2013	Customer Service Grievance Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Complaint	A complaint is the same as a Grievance. Where the Customer Service staff is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Exempt Grievance	Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response.
Grievance	A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by CalOptima to make an authorization decision.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Inquiry	A request for information that does not include an expression of dissatisfaction. Inquiries may include, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima processes.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Resolution	The grievance has reached a final conclusion with respect to the submitted Grievance.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

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Policy:	FF.2003
Title:	**Coordination of Benefits**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process for determining Coordination of Benefits (COB~~)*;~~), or order of payment, for payment of Covered Services when a Member has active coverage by more than one (1) group health plan.

II. POLICY

A. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan.

B. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort.

C. If a Member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the primary health plan shall pay for the medical, other care, or treatment benefits. CalOptima and a Health Network, as a secondary health plan and payer of last resort, shall adjudicate the claim based on amounts allowed by CalOptima and the primary health plan, whichever is less.

D. If CalOptima identifies OHC unknown to the Department of Health Care Services (DHCS), the Customer Service Department shall report this information to the DHCS Third Party Liability Branch, Other Coverage Unit, within ten (10) calendar days of discovery in an automated format as prescribed by DHCS.

E. An OHC plan, as the primary health plan, shall make payment as appropriate for a Member that has received services that fall within the OHC plan's scope of coverage, or shall deny payment as non-covered benefits, prior to payment consideration by CalOptima or a Health Network.

F. If a Member has both Medicare and an OHC plan, both Medicare and the OHC plan shall pay claims for services prior to payment consideration by CalOptima or a Health Network.

G. CalOptima and a Health Network shall not consider a claim for a Member with a Medicare supplemental policy through an insurance carrier as a Medicare/Medi-Cal Crossover Claim. CalOptima and a Health Network shall consider the Medicare supplemental insurance carrier as the primary health plan and CalOptima and a Health Network as the secondary health plan and the payer of last resort.

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H. CalOptima and a Health Network shall base the COB claim determination period upon the period of time that the Member is actively eligible for Medi-Cal benefits. If there is a break in eligibility and the dates of service falls within the period of time when the Member is not covered by Medi-Cal, CalOptima and the Health Network shall not apply the COB rules to the claim.

I. CalOptima and a Health Network shall make reasonable efforts to recover the value of Covered Services, also referred to as Post-Payment Recovery, or appropriately determine payment of claims for Covered Services, also known as Cost Avoidance, rendered to a Member whenever the Member is fully or partially covered for the same service under any other State or Federal medical care program or under contractual or legal entitlement including, but not limited to, a private group or indemnification program. CalOptima shall rely only on the Medi-Cal ~~Fame~~FAME File eligibility data provided by DHCS and loaded into FACETS™ to recover such payment for OHC.

J. CalOptima and a Health Network may contract with a third-party vendor to recover any payments as described in Section II.I. of this Policy.

K. CalOptima and a Health Network shall have the right to obtain and release COB information and may do so without consent from the Member, or the Member's Authorized Representative. CalOptima and a Health Network shall require a Member to provide insurers with any information needed to make COB determinations, and to pay claims.

L. A Member shall satisfy the monthly Share of Cost (SOC) dollar amount for medical expenses prior to CalOptima certifying the Member to receive Medi-Cal benefits. Upon eligibility certification, the Medi-Cal host computer shall provide an Eligibility Verification Confirmation (EVC) number.

1. CalOptima and a Health Network shall reduce the reimbursement made to a Provider for services rendered to a Member with a SOC by the SOC amount.

2. CalOptima may require a Member with a SOC who has OHC to pay a deductible or a co-payment amount up to his or her SOC. A Provider may bill CalOptima or a Health Network the remaining balance of the deductible or co-payment amount. CalOptima shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less.

3. If a Member has no SOC obligations, a Provider may bill CalOptima or a Health Network for the co-payment or deductible amount. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less (up to the co-pay or deductible amount).

M. A Provider shall not bill or collect deductible or co-payment amounts from a Member, except as provided in Section III.L. of this Policy.

N. Medicare Crossover

1. CalOptima or a Health Network shall pay the annual deductible or co-payment amount for a Member with Medicare Part A, Medicare Part B, or Medicare Part A and Part B, as required by current regulations. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

2. CalOptima or a Health Network shall pay a deductible or co-payment for Medicare Part A acute care inpatient services for a Member, in accordance with current Medi-Cal regulations.

O. ~~O. On a quarterly basis,~~ CalOptima and a Health Network shall maintain, and on a monthly basis submit, COB reports including, but not limited to reports on Post-Payment Recovery for other health coverage, in accordance with Section III.E. of this Policy and applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance. CalOptima and its Health Networks shall retain ~~COB~~such records for a period of at least ten (10) years after the termination of ~~its~~CalOptima's contract with ~~the~~ DHCS.

III. PROCEDURE

A. CalOptima and a Health Network shall use the following indicators to assess a Member's claim for possible OHC including, but not limited to:

1. Claim forms or Provider billings:
    a. CMS-1500;
    b. UB-04;
    c. PM160 (for dates of service through June 30, 2018 only); or
    d. 25-1.
2. CalOptima or FACETS™:
    a. Health plan carrier codes; or
    b. Medi-Cal eligibility aid codes.
3. Health Network:
    a. Health plan carrier code;
    b. Medi-Cal eligibility aid codes; or
    c. Other insurance information included in the CalOptima Member Eligibility tapes or through the file transfer protocol (FTP) site.
4. Automated Eligibility Verification System (AEVS): As listed on the Supplemental to AEVS Carrier Codes for Other Health Coverage;
5. Photocopies of Remittance Advice Details (RAD);
6. Explanation of Medicare Benefits (EOMB); or
7. Explanation of Payments to Providers (EOP) from other insurance payers.

B. COB Claims Process

1. CalOptima and a Health Network shall review the submitted claim form for indication of OHC. Pursuant to CMS-1500 or UB-04 claim forms, CalOptima and a Health Network shall utilize the following questions to review the claim form including, but not limited to:-

a. *Does the bill indicate the existence of other insurance coverage*?
Universal claim forms (CMS-1500, UB-04, PM160 (for dates of service through June 30, 2018 only), 25-1) used by physicians, hospitals, and other Providers usually indicate the type of coverage and the insurance carrier, and may provide the group plan name and number. (See Box 11d on CMS-1500 – Is There Another Health Benefit Plan).

b. *Has the bill been paid in part or in whole?*
An attachment to the claim submitted as evidence or explanation of benefits (EOB) may indicate that another plan has already provided benefits. (See Box 29 on CMS-1500 – Amount Paid).

c. *Is the spouse employed?*
If the spouse is employed, the Member may have coverage under the spouse's employer's group health plan. Dependent children may have coverage as dependents under the spouse's coverage. (See Box 9c on CMS-1500 – Employer's Name)

d. *Is the claimant covered by other plans that provide benefits or services?*
Claim forms usually request this information, along with the type of coverage, the name of the insurance carrier, and the group number. (See Box 9a-d on CMS-1500 – Other Insured's Name and Insurance Information)

e. *If the claimant is a child, does the last name differ from that of the insured or covered Member?*
This may indicate coverage through a second parent or a divorce situation in which natural and stepparents cover the child.

f. *Does the claim form indicate that the employee has a former employer?*
This may indicate that the claimant is receiving coverage as a retiree under the former employer's group health plan.

g. *Does the claim form indicate that the claimant is covered under the State or Federal health insurance continuation program?*
This may indicate coverage under a former employer's group health plan (e.g., COBRA).

h. *Is the claimant age sixty-five (65) or older?*
This may indicate the presence of Medicare coverage. (See Box 1 if the Medicare Box is checked and Box 3 on CMS-1500 – Patient's Birth Date)

i. *Is the claimant under age sixty-five (65) and diagnosed with end-stage renal disease (ESRD)?*
This may indicate that the claimant is entitled to Medicare coverage.

j. *If the claim was the result of an accident, where and how did it occur?*
This may indicate that the medical expenses are covered by a Third-Party Liability carrier, such as auto insurance or a homeowner's policy. (See Box 10b on CMS-1500 – Is Patient's Condition Related to Auto Accident or Box 21 on CMS-1500 – Description of Injury)

k. *Were the bills submitted as photocopies?*
This may indicate that the original bills were sent to another health plan carrier for payment.

l. *Were copies of the other carrier's evidence or explanation of benefits or payment submitted instead of the Provider's itemized bill?*
This usually indicates that the claimant has OHC.

m. *Does the system identify health plan carrier codes as evidence of OHC?*
If available, the Health Network information system should flag the claim for identification of OHC.

2. CalOptima or a Health Network shall not process a COB claim until the primary plan adjudicates the claim or OHC is verified.

3. CalOptima or a Health Network shall process a COB claim only if an Explanation of Benefits (EOB) from the primary carrier is attached. The primary payer shall pay, reject, or apply the COB claim to the deductible.

4. If CalOptima or a Health Network receives a COB claim without proof of disposition (i.e., EOB or reject letter) from the primary payer, CalOptima or a Health Network shall process the claim to the Provider using the appropriate denial reason code.

C. Application of COB rules

1. If a Provider is paid a fee-for-service rate or negotiated contract fee, CalOptima or a Health Network as the secondary payer, shall pay the difference between the amount paid by the OHC, as the primary plan, and the amount CalOptima, or a Health Network, would have paid in the absence of OHC.

a. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

b. The total of the payments issued by the OHC plan and CalOptima, or a Health Network, shall not exceed the normal plan benefits of CalOptima, or a Health Network.

2. If a claim is submitted by a Provider for a Covered Service that is not covered by the primary payer, CalOptima, or a Health Network, shall require that the Provider submit a denial letter or EOB from the primary payer with the claim prior to payment consideration.

3. In the absence of proof of payment or denial of benefits, the OHC plan shall certify that the policy had terminated, and the Member was no longer eligible at the time the services were rendered.

4. The Provider may bill CalOptima or a Health Network directly for payment for elective abortions not covered by TRICARE.

5. An OHC plan indicating coverage through TRICARE, Kaiser, other pre-paid health plan (PHP) or health maintenance organization (HMO), and other organizations not contracting with CalOptima, or a Health Network, to provide services, shall pay for services prior to reimbursement consideration by CalOptima or a Health Network for those services.

6. CalOptima or a Health Network shall pay for Covered Services that are not covered by a PHP, or HMO, if the claim is accompanied by a denial letter from the PHP or HMO.

D. A Provider shall submit a claim for a Member who is eligible for both Medicare and Medi-Cal to Medicare prior to billing CalOptima or a Health Network.

1. Medicare Part A (hospital only)

a. If a Member has Medicare Part A only, a Provider shall submit a claim to Medicare for payment of the hospital charges and the facility or technical component fees of the ancillary charges.

b. CalOptima or a Health Network shall pay Crossover Claims for the Medicare co-insurance and the annual deductible amounts not payable by Medicare.

c. CalOptima or a Health Network shall pay the Medicare Part B component for inpatient services covered by Medicare.

d. Medicare Part A Covered Services include, but are not limited to:

i. Inpatient hospital care;

ii. Psychiatric hospital care;

iii. Skilled nursing facility;

iv. Hospice care; and

v. Respite care.

e. A Provider shall submit a Medicare RAD with the claim for payment of Medicare Part B services to CalOptima or a Health Network for payment consideration.

2. Medicare Part B (outpatient physician services)

a. If a Member has Medicare Part B only, a Provider shall submit a claim for inpatient hospital and facility charges up to the maximum allowed by CalOptima inpatient rates to CalOptima or a Health Network the primary payer for inpatient hospital and facility charges.

b. A Provider shall submit a claim for physician services and professional component fees of the hospital ancillary charges (e.g., laboratory, radiology, therapy) to Medicare, the primary payer for all physician services and professional component fees of the hospital ancillary charges.

c. CalOptima or a Health Network as the secondary payer, shall pay for the following:

i. Medicare Part A component less the Medicare payment;

ii. Medicare co-insurance; and

iii. Annual deductible amount for Medicare Part B services.

d. Medicare Part B Covered Services include, but are not limited to:

i. Physician services;

ii. Outpatient hospital treatments;

iii. Home health visits;

iv. Inpatient and outpatient medical services and supplies;

v. Blood supplies; and

vi. Other medical and health services, including but not limited to:

1) Transportation;

2) Home dialysis equipment;

3) Oral surgery;

4) Outpatient physical therapy;

5) Speech pathology;

6) Diagnostic radiology;

7) Radiation treatments;

8) Pathology and laboratory;

9) Psychology and occupational therapy (50% payable); and

10) Limited vision.

e. A Provider shall submit claims for Medicare Part B services to Medicare Part B carriers, in accordance with the EOMB.

f. A Provider shall submit claims for Medicare Part A services to Medicare Part A carriers, in accordance with the Remittance Advice Details.

3. Medicare Part A and Part B

a. If a Member has Medicare Part A and Part B, a Provider shall submit a claim to Medicare, the primary payer.

b. CalOptima, or a Health Network, as a secondary payer, shall pay the amount billed for the Medicare co-insurance or annual deductibles for Medicare Part A, Medicare Part B, or Medicare Part A and Part B coverage.

4. If a Member who is entitled to Medicare is enrolled in a Medicare risk-sharing HMO plan, a Provider shall submit a claim to the HMO plan, the primary payer. CalOptima shall remain the secondary payer.

E. Post-Payment Recovery Reporting

1. In accordance with DHCS requirements, CalOptima and a Health Network must engage in Post-Payment Recovery if OHC is discovered retroactively or the Member had an OHC "A" indicator on the Medi-Cal eligibility record.

a. Beginning October 1, 2020, Health Networks shall submit the monthly Post-Payment Recovery Template report (Attachment C) to CalOptima as follows:

i. A Health Network shall submit a report for Post-Payment Recoveries by the third (3rd) calendar day of the month, or the first (1st) business day thereafter, if the third (3rd) falls on a weekend or holiday to CalOptima's FTP site. A Health Network shall submit the report using CalOptima's format and file naming convention.

ii. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than two (2) 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 fifth (5th) calendar day of the following month, or the first (1st) business day if the fifth (5th) falls on a weekend or holiday. Any resubmission after the fifth (5th) business day of the calendar month will be included in the subsequent month's process.

2. CalOptima will submit detailed information regarding recoveries to include CalOptima and Health Network data to DHCS in a monthly report utilizing DHCS secure File Transfer Protocol (sFTP) no later than the fifteenth (15th) of each month using the format and file naming convention required by DHCS.

3. If CalOptima or a Health Network initiates and completes Post-Payment Recovery within twelve (12) months from the date of payment of a service, CalOptima or the Health Network is entitled to retain all monies recovered.

a. CalOptima shall remit warrants, payable to DHCS, for all recovered monies that are thirteen (13) months or older from the date of payment to the following address:

Bank of America
P.O. Box 742635
Los Angeles, CA 90074-2635.

b. DHCS Third Party Liability and Recovery Division (TPLRD) will conduct Post-Payment Recoveries and/or leverage its recovery contractor to initiate Post-Payment Recovery beginning the thirteenth (13th) month following the date of payment. Monies recovered by TPLRD will be retained by DHCS.

4. Beginning January 1, 2021, CalOptima or a Health Network shall include in the notification to the provider when a claim is denied due to the presence of OHC. Notification should include but is not limited to:

a. Name of the OHC provider;

b. Policy number; and

c. OHC contact or billing information.

~~E.~~F. In accordance with DHCS requirements, COB reports maintained by CalOptima and a Health Network shall display claim counts and dollar amounts of costs avoided and the amount of ~~post-payment recoveries~~Post- Payment Recoveries by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. CalOptima and a Health Network shall make the reports available to DHCS upon request.

IV. ATTACHMENT(S)

A. CMS-1500 Form
B. UB-04 Form
C. Post-Payment Recovery Template Appendix B

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Coordination of Benefits Handbook, Business & Legal Resources (BLR), Copyright 2019
C. Title 22, California Code of Regulations (C.C.R), Division 3: Health Care Services, Chapter 2, Articles 12 & 15
D. Department of Health Care Services (DHCS) All Plan Letter 20-010 Cost Avoidance and Post-Payment Recovery for Other Health Coverage

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2008	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2009	FF.2003	Coordination of Benefits	Medi-Cal
Revised	10/01/2016	FF.2003	Coordination of Benefits	Medi-Cal
Revised	06/07/2018	FF.2003	Coordination of Benefits	Medi-Cal
Revised	07/01/2019	FF.2003	Coordination of Benefits	Medi-Cal
Revised	TBD	FF.2003	Coordination of Benefits	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Coordination of Benefits	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Cost Avoidance	Practice of requiring a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to seeking payment from the CalOptima Medi-Cal program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and 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~~notwithstanding whether such benefits are provided under the
Crossover Claim	A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
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.

Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal Obligation, excluding tort liability.
Post-Payment Recovery	All reasonable measures taken to determine the legal liability of third parties and seek reimbursement for Covered Services for which the third party is liable.
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
Share of Cost (SOC)	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.

Policy:	FF.2003
Title:	**Coordination of Benefits**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process for determining Coordination of Benefits (COB), or order of payment, for payment of Covered Services when a Member has active coverage by more than one (1) group health plan.

II. POLICY

A. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan.

B. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort.

C. If a Member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the primary health plan shall pay for the medical, other care, or treatment benefits. CalOptima and a Health Network, as a secondary health plan and payer of last resort, shall adjudicate the claim based on amounts allowed by CalOptima and the primary health plan, whichever is less.

D. If CalOptima identifies OHC unknown to the Department of Health Care Services (DHCS), the Customer Service Department shall report this information to the DHCS Third Party Liability Branch, Other Coverage Unit, within ten (10) calendar days of discovery in an automated format as prescribed by DHCS.

E. An OHC plan, as the primary health plan, shall make payment as appropriate for a Member that has received services that fall within the OHC plan's scope of coverage, or shall deny payment as non-covered benefits, prior to payment consideration by CalOptima or a Health Network.

F. If a Member has both Medicare and an OHC plan, both Medicare and the OHC plan shall pay claims for services prior to payment consideration by CalOptima or a Health Network.

G. CalOptima and a Health Network shall not consider a claim for a Member with a Medicare supplemental policy through an insurance carrier as a Medicare/Medi-Cal Crossover Claim. CalOptima and a Health Network shall consider the Medicare supplemental insurance carrier as the primary health plan and CalOptima and a Health Network as the secondary health plan and the payer of last resort.

Back to Agenda Back to Item

H. CalOptima and a Health Network shall base the COB claim determination period upon the period of time that the Member is actively eligible for Medi-Cal benefits. If there is a break in eligibility and the dates of service falls within the period of time when the Member is not covered by Medi-Cal, CalOptima and the Health Network shall not apply the COB rules to the claim.

I. CalOptima and a Health Network shall make reasonable efforts to recover the value of Covered Services, also referred to as Post-Payment Recovery, or appropriately determine payment of claims for Covered Services, also known as Cost Avoidance, rendered to a Member whenever the Member is fully or partially covered for the same service under any other State or Federal medical care program or under contractual or legal entitlement including, but not limited to, a private group or indemnification program. CalOptima shall rely only on the Medi-Cal FAME File eligibility data provided by DHCS and loaded into FACETS™ to recover such payment for OHC.

J. CalOptima and a Health Network may contract with a third-party vendor to recover any payments as described in Section II.I. of this Policy.

K. CalOptima and a Health Network shall have the right to obtain and release COB information and may do so without consent from the Member, or the Member's Authorized Representative. CalOptima and a Health Network shall require a Member to provide insurers with any information needed to make COB determinations, and to pay claims.

L. A Member shall satisfy the monthly Share of Cost (SOC) dollar amount for medical expenses prior to CalOptima certifying the Member to receive Medi-Cal benefits. Upon eligibility certification, the Medi-Cal host computer shall provide an Eligibility Verification Confirmation (EVC) number.

1. CalOptima and a Health Network shall reduce the reimbursement made to a Provider for services rendered to a Member with a SOC by the SOC amount.

2. CalOptima may require a Member with a SOC who has OHC to pay a deductible or a co-payment amount up to his or her SOC. A Provider may bill CalOptima or a Health Network the remaining balance of the deductible or co-payment amount. CalOptima shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less.

3. If a Member has no SOC obligations, a Provider may bill CalOptima or a Health Network for the co-payment or deductible amount. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less (up to the co-pay or deductible amount).

M. A Provider shall not bill or collect deductible or co-payment amounts from a Member, except as provided in Section III.L. of this Policy.

N. Medicare Crossover

1. CalOptima or a Health Network shall pay the annual deductible or co-payment amount for a Member with Medicare Part A, Medicare Part B, or Medicare Part A and Part B, as required by current regulations. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

2. CalOptima or a Health Network shall pay a deductible or co-payment for Medicare Part A acute care inpatient services for a Member, in accordance with current Medi-Cal regulations.

O. CalOptima and a Health Network shall maintain, and on a monthly basis submit, COB reports including, but not limited to reports on Post-Payment Recovery for other health coverage, in accordance with Section III.E. of this Policy and applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance. CalOptima and its Health Networks shall retain such records for a period of at least ten (10) years after the termination of CalOptima's contract with DHCS.

III. PROCEDURE

A. CalOptima and a Health Network shall use the following indicators to assess a Member's claim for possible OHC including, but not limited to:

1. Claim forms or Provider billings:
    a. CMS-1500;
    b. UB-04;
    c. PM160 (for dates of service through June 30, 2018 only); or
    d. 25-1.
2. CalOptima or FACETS™:
    a. Health plan carrier codes; or
    b. Medi-Cal eligibility aid codes.
3. Health Network:
    a. Health plan carrier code;
    b. Medi-Cal eligibility aid codes; or
    c. Other insurance information included in the CalOptima Member Eligibility tapes or through the file transfer protocol (FTP) site.
4. Automated Eligibility Verification System (AEVS): As listed on the Supplemental to AEVS Carrier Codes for Other Health Coverage;
5. Photocopies of Remittance Advice Details (RAD);
6. Explanation of Medicare Benefits (EOMB); or
7. Explanation of Payments to Providers (EOP) from other insurance payers.

B. COB Claims Process

1. CalOptima and a Health Network shall review the submitted claim form for indication of OHC. Pursuant to CMS-1500 or UB-04 claim forms, CalOptima and a Health Network shall utilize the following questions to review the claim form including, but not limited to:

a. *Does the bill indicate the existence of other insurance coverage*?
Universal claim forms (CMS-1500, UB-04, PM160 (for dates of service through June 30, 2018 only), 25-1) used by physicians, hospitals, and other Providers usually indicate the type of coverage and the insurance carrier and may provide the group plan name and number. (See Box 11d on CMS-1500 – Is There Another Health Benefit Plan).

b. *Has the bill been paid in part or in whole?*
An attachment to the claim submitted as evidence or explanation of benefits (EOB) may indicate that another plan has already provided benefits. (See Box 29 on CMS-1500 – Amount Paid).

c. *Is the spouse employed?*
If the spouse is employed, the Member may have coverage under the spouse's employer's group health plan. Dependent children may have coverage as dependents under the spouse's coverage. (See Box 9c on CMS-1500 – Employer's Name)

d. *Is the claimant covered by other plans that provide benefits or services?*
Claim forms usually request this information, along with the type of coverage, the name of the insurance carrier, and the group number. (See Box 9a-d on CMS-1500 – Other Insured's Name and Insurance Information)

e. *If the claimant is a child, does the last name differ from that of the insured or covered Member?*
This may indicate coverage through a second parent or a divorce situation in which natural and stepparents cover the child.

f. *Does the claim form indicate that the employee has a former employer?*
This may indicate that the claimant is receiving coverage as a retiree under the former employer's group health plan.

g. *Does the claim form indicate that the claimant is covered under the State or Federal health insurance continuation program?*
This may indicate coverage under a former employer's group health plan (e.g., COBRA).

h. *Is the claimant age sixty-five (65) or older?*
This may indicate the presence of Medicare coverage. (See Box 1 if the Medicare Box is checked and Box 3 on CMS-1500 – Patient's Birth Date)

i. *Is the claimant under age sixty-five (65) and diagnosed with end-stage renal disease (ESRD)?*
This may indicate that the claimant is entitled to Medicare coverage.

j. *If the claim was the result of an accident, where and how did it occur?*
This may indicate that the medical expenses are covered by a Third-Party Liability carrier, such as auto insurance or a homeowner's policy. (See Box 10b on CMS-1500 – Is Patient's Condition Related to Auto Accident or Box 21 on CMS-1500 – Description of Injury)

k. *Were the bills submitted as photocopies?*
This may indicate that the original bills were sent to another health plan carrier for payment.

l. *Were copies of the other carrier's evidence or explanation of benefits or payment submitted instead of the Provider's itemized bill?*
This usually indicates that the claimant has OHC.

m. *Does the system identify health plan carrier codes as evidence of OHC?*
If available, the Health Network information system should flag the claim for identification of OHC.

2. CalOptima or a Health Network shall not process a COB claim until the primary plan adjudicates the claim or OHC is verified.

3. CalOptima or a Health Network shall process a COB claim only if an Explanation of Benefits (EOB) from the primary carrier is attached. The primary payer shall pay, reject, or apply the COB claim to the deductible.

4. If CalOptima or a Health Network receives a COB claim without proof of disposition (i.e., EOB or reject letter) from the primary payer, CalOptima or a Health Network shall process the claim to the Provider using the appropriate denial reason code.

C. Application of COB rules

1. If a Provider is paid a fee-for-service rate or negotiated contract fee, CalOptima or a Health Network as the secondary payer, shall pay the difference between the amount paid by the OHC, as the primary plan, and the amount CalOptima, or a Health Network, would have paid in the absence of OHC.

a. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

b. The total of the payments issued by the OHC plan and CalOptima, or a Health Network, shall not exceed the normal plan benefits of CalOptima, or a Health Network.

2. If a claim is submitted by a Provider for a Covered Service that is not covered by the primary payer, CalOptima, or a Health Network, shall require that the Provider submit a denial letter or EOB from the primary payer with the claim prior to payment consideration.

3. In the absence of proof of payment or denial of benefits, the OHC plan shall certify that the policy had terminated, and the Member was no longer eligible at the time the services were rendered.

4. The Provider may bill CalOptima or a Health Network directly for payment for elective abortions not covered by TRICARE.

5. An OHC plan indicating coverage through TRICARE, Kaiser, other pre-paid health plan (PHP) or health maintenance organization (HMO), and other organizations not contracting with CalOptima, or a Health Network, to provide services, shall pay for services prior to reimbursement consideration by CalOptima or a Health Network for those services.

6. CalOptima or a Health Network shall pay for Covered Services that are not covered by a PHP, or HMO, if the claim is accompanied by a denial letter from the PHP or HMO.

D. A Provider shall submit a claim for a Member who is eligible for both Medicare and Medi-Cal to Medicare prior to billing CalOptima or a Health Network.

1. Medicare Part A (hospital only)

a. If a Member has Medicare Part A only, a Provider shall submit a claim to Medicare for payment of the hospital charges and the facility or technical component fees of the ancillary charges.

b. CalOptima or a Health Network shall pay Crossover Claims for the Medicare co-insurance and the annual deductible amounts not payable by Medicare.

c. CalOptima or a Health Network shall pay the Medicare Part B component for inpatient services covered by Medicare.

d. Medicare Part A Covered Services include, but are not limited to:

i. Inpatient hospital care;

ii. Psychiatric hospital care;

iii. Skilled nursing facility;

iv. Hospice care; and

v. Respite care.

e. A Provider shall submit a Medicare RAD with the claim for payment of Medicare Part B services to CalOptima or a Health Network for payment consideration.

2. Medicare Part B (outpatient physician services)

a. If a Member has Medicare Part B only, a Provider shall submit a claim for inpatient hospital and facility charges up to the maximum allowed by CalOptima inpatient rates to CalOptima or a Health Network the primary payer for inpatient hospital and facility charges.

b. A Provider shall submit a claim for physician services and professional component fees of the hospital ancillary charges (e.g., laboratory, radiology, therapy) to Medicare, the primary payer for all physician services and professional component fees of the hospital ancillary charges.

c. CalOptima or a Health Network as the secondary payer, shall pay for the following:

i. Medicare Part A component less the Medicare payment;

ii. Medicare co-insurance; and

iii. Annual deductible amount for Medicare Part B services.

d. Medicare Part B Covered Services include, but are not limited to:

i. Physician services;

ii. Outpatient hospital treatments;

iii. Home health visits;

iv. Inpatient and outpatient medical services and supplies;

v. Blood supplies; and

vi. Other medical and health services, including but not limited to:

1) Transportation;

2) Home dialysis equipment;

3) Oral surgery;

4) Outpatient physical therapy;

5) Speech pathology;

6) Diagnostic radiology;

7) Radiation treatments;

8) Pathology and laboratory;

9) Psychology and occupational therapy (50% payable); and

10) Limited vision.

e. A Provider shall submit claims for Medicare Part B services to Medicare Part B carriers, in accordance with the EOMB.

f. A Provider shall submit claims for Medicare Part A services to Medicare Part A carriers, in accordance with the Remittance Advice Details.

3. Medicare Part A and Part B

a. If a Member has Medicare Part A and Part B, a Provider shall submit a claim to Medicare, the primary payer.

b. CalOptima, or a Health Network, as a secondary payer, shall pay the amount billed for the Medicare co-insurance or annual deductibles for Medicare Part A, Medicare Part B, or Medicare Part A and Part B coverage.

4. If a Member who is entitled to Medicare is enrolled in a Medicare risk-sharing HMO plan, a Provider shall submit a claim to the HMO plan, the primary payer. CalOptima shall remain the secondary payer.

E. Post-Payment Recovery Reporting

1. In accordance with DHCS requirements, CalOptima and a Health Network must engage in Post-Payment Recovery if OHC is discovered retroactively or the Member had an OHC "A" indicator on the Medi-Cal eligibility record.

a. Beginning October 1, 2020, Health Networks shall submit the monthly Post-Payment Recovery Template report (Attachment C) to CalOptima as follows:

i. A Health Network shall submit a report for Post-Payment Recoveries by the third (3rd) calendar day of the month, or the first (1st) business day thereafter, if the third (3rd) falls on a weekend or holiday to CalOptima's FTP site. A Health Network shall submit the report using CalOptima's format and file naming convention.

ii. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than two (2) 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 fifth (5th) calendar day of the following month, or the first (1st) business day if the fifth (5th) falls on a weekend or holiday. Any resubmission after the fifth (5th) business day of the calendar month will be included in the subsequent month's process.

2. CalOptima will submit detailed information regarding recoveries to include CalOptima and Health Network data to DHCS in a monthly report utilizing DHCS secure File Transfer Protocol (sFTP) no later than the fifteenth (15th) of each month using the format and file naming convention required by DHCS.

3. If CalOptima or a Health Network initiates and completes Post-Payment Recovery within twelve (12) months from the date of payment of a service, CalOptima or the Health Network is entitled to retain all monies recovered.

   a. CalOptima shall remit warrants, payable to DHCS, for all recovered monies that are thirteen (13) months or older from the date of payment to the following address:

      Bank of America
      P.O. Box 742635
      Los Angeles, CA 90074-2635.

   b. DHCS Third Party Liability and Recovery Division (TPLRD) will conduct Post-Payment Recoveries and/or leverage its recovery contractor to initiate Post-Payment Recovery beginning the thirteenth (13th) month following the date of payment. Monies recovered by TPLRD will be retained by DHCS.

4. Beginning January 1, 2021, CalOptima or a Health Network shall include in the notification to the provider when a claim is denied due to the presence of OHC. Notification should include but is not limited to:

   a. Name of the OHC provider;

   b. Policy number; and

   c. OHC contact or billing information.

F. In accordance with DHCS requirements, COB reports maintained by CalOptima and a Health Network shall display claim counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. CalOptima and a Health Network shall make the reports available to DHCS upon request.

IV. ATTACHMENT(S)

A. CMS-1500 Form
B. UB-04 Form
C. Post-Payment Recovery Template Appendix B

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Coordination of Benefits Handbook, Business & Legal Resources (BLR), Copyright 2019
C. Title 22, California Code of Regulations (C.C.R), Division 3: Health Care Services, Chapter 2, Articles 12 & 15
D. Department of Health Care Services (DHCS) All Plan Letter 20-010 Cost Avoidance and Post-Payment Recovery for Other Health Coverage

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2008	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2009	FF.2003	Coordination of Benefits	Medi-Cal
Revised	10/01/2016	FF.2003	Coordination of Benefits	Medi-Cal
Revised	06/07/2018	FF.2003	Coordination of Benefits	Medi-Cal
Revised	07/01/2019	FF.2003	Coordination of Benefits	Medi-Cal
Revised	TBD	FF.2003	Coordination of Benefits	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Coordination of Benefits	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Cost Avoidance	Practice of requiring a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to seeking payment from the CalOptima Medi-Cal program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (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.
Crossover Claim	A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
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.

Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal Obligation, excluding tort liability.
Post-Payment Recovery	All reasonable measures taken to determine the legal liability of third parties and seek reimbursement for Covered Services for which the third party is liable.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Share of Cost (SOC)	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.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
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16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE ____ OF ____	CREATION DATE		TOTALS			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A						57	A
B						OTHER	B
C						PRV ID	C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A					A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO.

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APPENDIX B

Field Name	Format	Field Description
Project Type	Text	(Third Party Liability (TPL), Credit Balance Audit, Retro Eligibility, Medicaid Fraud Control Unit, Professional Practice Insurance Broker, Other)
Provider Name	Text	(Institutional= Facility Name, Professional = Rendering Name)
Provider TIN	Text	Provider Federal Tax ID Number
Claim Type	Text	(Inst, Prof, Pharmacy, Dental)
Medicaid Number	Text	Recipient Identification Number
Recipient SS#	Numeric	Recipient Social Security Number (leave blank if unknown)
Client First name	General	Client First name
Client Last name	General	Client Last name
Date of Birth	MM-DD-YYYY	Recipient Date of Birth
TCN	TEXT	Managed Care health plan (MCP) Claim Transaction Control Number
Begin DOS	MM-DD-YYYY	Begin date of service
End DOS	MM-DD-YYYY	End date of service
CCO Bill amount	Currency	Coordinated Care Organization (CCO) Amount billed to TPL
CCO Paid amount	Currency	CCO Amount MCP paid to the Provider
Bill date	MM-DD-YYYY	Date the claim was billed to the TPL
Remit amount	Currency	Amount Recovered from TPL
Claim date of remit	MM-DD-YYYY	Date the claim was paid or denied by TPL (leave blank if claims is open)
Check Number	General	Check number
Other Insurance carrier name	General	Name of TPL that was billed
Claim status	General	Disposition of claims (Paid, Denied, Open, etc)
Denial Reason	General	The reason the claim was denied

1) File should be uploaded to the Department of Health Care Services Secure File Transfer Protocol (SFTP) no later than the 15th of each month.
2) File should be in xlsx format.
3) Files should have the following naming convention MCPPR."MCP Short Name"_YYYY_MM_DD.xslx
Please see below for a list of MCP Short Names and file naming conventions.
4) MCP contract representatives will be sent a username and password to access the SFTP prior to May 1, 2020

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APPENDIX B

MCP Full Name	MCP Short Name	SFTP File Naming Convention
Aetna	Aetna	MCPPR.Aetna_YYYY_MM_DD.xslx
AIDS Health Foundation	AHF	MCPPR.AHF_YYYY_MM_DD.xslx
Alameda Alliance for Health	AAH	MCPPR.AAH_YYYY_MM_DD.xslx
Anthem Blue Cross	ABC	MCPPR.ABC_YYYY_MM_DD.xslx
Blue Shield Promise	BSP	MCPPR.BSP_YYYY_MM_DD.xslx
California Health and Wellness	CHW	MCPPR.CHW_YYYY_MM_DD.xslx
CalOptima	CO	MCPPR.CO_YYYY_MM_DD.xslx
CalViva Health Plan	CVHP	MCPPR.CVHP_YYYY_MM_DD.xslx
CenCal	CenCal	MCPPR.CenCal_YYYY_MM_DD.xslx
Central CA Alliance for Health	CCAH	MCPPR.CCAH_YYYY_MM_DD.xslx
Community Health Group	CHG	MCPPR.CHG_YYYY_MM_DD.xslx
Contra Costa Health Plan	CCHP	MCPPR.CCHP_YYYY_MM_DD.xslx
Family Mosaic	FM	MCPPR.FM_YYYY_MM_DD.xslx
Gold Coast Health Plan	GCHP	MCPPR.GHCP_YYYY_MM_DD.xslx
Health Net	HN	MCPPR.HN_YYYY_MM_DD.xslx
Health Plan of San Mateo	HPSM	MCPPR.HPSM_YYYY_MM_DD.xslx
Health Plan San Joaquin	HPSJ	MCPPR.HPSJ_YYYY_MM_DD.xslx
Healthy San Diego	HSD	MCPPR.HSD_YYYY_MM_DD.xslx
Inland Empire Health Plan	IEHP	MCPPR.IEHP_YYYY_MM_DD.xslx
Kaiser Permanente	KP	MCPPR.KP_YYYY_MM_DD.xslx
Kern Health Systems	KHS	MCPPR.KHS_YYYY_MM_DD.xslx
LA Care	LACare	MCPPR.LACare_YYYY_MM_DD.xslx
Molina	Molina	MCPPR.Molina_YYYY_MM_DD.xslx
Partnership Health Plan	PHP	MCPPR.PHP_YYYY_MM_DD.xslx
Rady	Rady	MCPPR.Rady_YYYY_MM_DD.xslx
San Francisco Health Plan	SFHP	MCPPR.SFHP_YYYY_MM_DD.xslx
Santa Clara Family Health Plan	SCFHP	MCPPR.SCFHP_YYYY_MM_DD.xslx
SCAN	SCAN	MCPPR.SCAN_YYYY_MM_DD.xslx
United Healthcare	UHC	MCPPR.UHC_YYYY_MM_DD.xslx

Back to Agenda

Back to Item

Policy:	FF.2005
Title:	**Conlan, Member Reimbursement**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima's process to comply with the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, the court-ordered reimbursement process to Members for paid out-of-pocket expenses for Medi-Cal Covered Services.

II. POLICY

A. CalOptima, in compliance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, and in accordance with applicable state and federal regulations, shall reimburse Members for out-of-pocket expenses for Covered Services through the terms and conditions of this Policy.

B. If CalOptima or a Health Network denies all or part of the Member's claim, the Member shall have the right to appeal the decision in accordance with CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~.

C. Providers and Practitioners shall have the option to file a State Hearing and provide evidence that the proposed reimbursement and recoupment is not correct for *Conlan* claims only.

D. CalOptima may recoup from Health Networks, Providers, and Practitioners to reimburse a Member in accordance to the provisions set forth in this Policy.

E. CalOptima, its Health Networks, Providers, and Practitioners shall not submit claims to, or demand, or otherwise collect reimbursement from, a Member, in accordance to Title 22, California Code of Regulations, Section 51002.

F. CalOptima shall report and investigate any suspected Fraud, Waste, and Abuse matters, pursuant to CalOptima Policies HH.1105Δ: Fraud and Abuse Detection and HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting.

G. If a Member does not fully comply with the provisions set forth in this Policy, CalOptima may deny the Member's claim.

III. PROCEDURE

A. Subject to the provisions of this Policy, and in accordance with the MMCD All Plan Letter 07-002, CalOptima shall reimburse a Member for paid out-of-pocket expenses for Covered Services received on and after June 27, 1997, during the following specific periods of a Member's eligibility:

1. The post-approval period (the time period after eligibility has been established).

~~B.~~ CalOptima and its Health Networks shall only be responsible to provide reimbursement for Covered Services for which CalOptima and its Health Networks receive Capitation Payment, subject to all applicable CalOptima and Health Network utilization protocols, policies, and procedures as of the date of service, including, but not limited to:

~~C.~~

~~Pharmacy limits, as set forth in CalOptima Policy GG.1413: Polypharmacy Management;~~

~~Pharmacy Home Program, as set forth in CalOptima Policy GG.1416: Pharmacy Home Program;~~

B.

1. Pharmacy limits, as set forth in CalOptima Policy GG.1413: Polypharmacy Management for dates of service on or before December 31, 2020;

2. Pharmacy Home Program, as set forth in CalOptima Policy GG.1416: Pharmacy Home Program for dates of service on or before December 31, 2020;

~~1.~~3. Utilization Management controls and limitations, as set forth in CalOptima Policy GG.1508: Authorization and Processing of Referrals;

~~2.~~4. Non-emergency transportation, as set forth in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical;

~~3.~~5. Disposable incontinence supplies, as set forth in CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies; and

~~4.~~6. Durable Medical Equipment (DME), as set forth in CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs.

C. CalOptima and its Health Networks are not obligated to provide reimbursement for the following services:

1. Carved-Out Services (i.e., Medi-Cal services for which CalOptima and its Health Networks are not responsible);

2. Services rendered to a Member during a time period outside of those specified in Section III.A. of this Policy;

3. Services for which pre-authorization was required but not obtained, in accordance to CalOptima Policy GG.1508: Authorization and Processing of Referrals;

4. Services for which a Member went out-of-network to receive non-emergency services; and

5. Services that were rendered by a Provider or Practitioner who does not have a valid Medi-Cal Provider number.

D. CalOptima shall adjudicate *Conlan* reimbursement claims within one hundred twenty (120) calendar days after CalOptima's receipt of a completed claim packet from the Department of Health Care Services (DHCS) or its agent for CalOptima-covered expenses incurred and paid during the time periods referenced in Section III.A. of this Policy. Excluded from the *Conlan* Adjudication Period are the time periods between mailing of a notice to a Member that additional information is required to process a claim, and receipt of such information, and any period during which a recoupment action is in effect against the Provider who owes a reimbursement.

IV. ATTACHMENT(S)

A. Provider Notice A: CalOptima Requests Medi-Cal Provider to Reimburse the Member
B. Provider Notice B: CalOptima Requests Non-Medi-Cal Provider to Reimburse the Member
C. Provider Notice C: Provider Obligation to Reimburse Member and Submit Claim to CalOptima
D. Member Notice A: Claim Closed due to Full Reimbursement from Provider
E. Member Notice B: Additional Information Required to Process Claim
F. Member Notice C: Claim Denial
G. Member Notice D: Direct Reimbursement from CalOptima to Member for Medi-Cal Rate
H. Member Notice E: Confirmation of Receipt of Claim

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy HH.1105Δ: Fraud and Abuse Detection
C. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
D. CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies
~~E. CalOptima Policy GG.1413: Polypharmacy Management~~CalOptima Policy GG.1413: Polypharmacy Management
~~F.~~E. ~~CalOptima Policy GG.1416: Pharmacy Home Program~~
~~G.~~F. CalOptima Policy GG.1416: Pharmacy Home Program
~~H.~~
~~I.~~G. CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
~~J.~~H. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
~~K.~~I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~L.~~J. CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~
~~M.~~K. Department of Health Care Services (DHCS) Notice to Medi-Cal beneficiaries
L. Department of Health Care Services (DHCS) Notice to Medi-Cal Rx: Post Transition roles & Responsibilities
~~N.~~M. Department of Health Care Services (DHCS) All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process
~~O.~~N. Title 22, California Code of Regulations (CCR), Section 51002

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	07/01/2009	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	03/01/2012	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	10/01/2016	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2017	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2018	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	05/01/2019	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	TBD	FF.2005	Conlan, Member Reimbursement	Medi-Cal

IX. GLOSSARY

Term	Definition
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
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), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members ~~not withstanding~~notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Durable Medical Equipment (DME)	Any equipment, other than prosthetic or orthotic appliances, that is prescribed by a licensed Practitioner to meet the medical equipment needs of the Member that: 1. Can withstand repeated use; 2. Is used to serve a medical purpose; 3. Is not useful to a Member in the absence of an illness, injury, functional impairment or congenital anomaly; and 4. Is appropriate for use in or outside of the Member's home.
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.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

1

Policy:	FF.2005
Title:	**Conlan, Member Reimbursement**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima's process to comply with the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, the court-ordered reimbursement process to Members for paid out-of-pocket expenses for Medi-Cal Covered Services.

II. POLICY

A. CalOptima, in compliance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, and in accordance with applicable state and federal regulations, shall reimburse Members for out-of-pocket expenses for Covered Services through the terms and conditions of this Policy.

B. If CalOptima or a Health Network denies all or part of the Member's claim, the Member shall have the right to appeal the decision in accordance with CalOptima Policy GG.1510: Appeal Process.

C. Providers and Practitioners shall have the option to file a State Hearing and provide evidence that the proposed reimbursement and recoupment is not correct for *Conlan* claims only.

D. CalOptima may recoup from Health Networks, Providers, and Practitioners to reimburse a Member in accordance to the provisions set forth in this Policy.

E. CalOptima, its Health Networks, Providers, and Practitioners shall not submit claims to, or demand, or otherwise collect reimbursement from, a Member, in accordance to Title 22, California Code of Regulations, Section 51002.

F. CalOptima shall report and investigate any suspected Fraud, Waste, and Abuse matters, pursuant to CalOptima Policies HH.1105Δ: Fraud and Abuse Detection and HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting.

G. If a Member does not fully comply with the provisions set forth in this Policy, CalOptima may deny the Member's claim.

III. PROCEDURE

A. Subject to the provisions of this Policy, and in accordance with the MMCD All Plan Letter 07-002, CalOptima shall reimburse a Member for paid out-of-pocket expenses for Covered Services received on and after June 27, 1997, during the following specific periods of a Member's eligibility:

1. The post-approval period (the time period after eligibility has been established).

B. CalOptima and its Health Networks shall only be responsible to provide reimbursement for Covered Services for which CalOptima and its Health Networks receive Capitation Payment, subject to all applicable CalOptima and Health Network utilization protocols, policies, and procedures as of the date of service, including, but not limited to:

1. Pharmacy limits, as set forth in CalOptima Policy GG.1413: Polypharmacy Management for dates of service on or before December 31, 2020;

2. Pharmacy Home Program, as set forth in CalOptima Policy GG.1416: Pharmacy Home Program for dates of service on or before December 31, 2020;

3. Utilization Management controls and limitations, as set forth in CalOptima Policy GG.1508: Authorization and Processing of Referrals;

4. Non-emergency transportation, as set forth in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical;

5. Disposable incontinence supplies, as set forth in CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies; and

6. Durable Medical Equipment (DME), as set forth in CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs.

C. CalOptima and its Health Networks are not obligated to provide reimbursement for the following services:

1. Carved-Out Services (i.e., Medi-Cal services for which CalOptima and its Health Networks are not responsible);

2. Services rendered to a Member during a time period outside of those specified in Section III.A. of this Policy;

3. Services for which pre-authorization was required but not obtained, in accordance to CalOptima Policy GG.1508: Authorization and Processing of Referrals;

4. Services for which a Member went out-of-network to receive non-emergency services; and

5. Services that were rendered by a Provider or Practitioner who does not have a valid Medi-Cal Provider number.

D. CalOptima shall adjudicate *Conlan* reimbursement claims within one hundred twenty (120) calendar days after CalOptima's receipt of a completed claim packet from the Department of Health Care Services (DHCS) or its agent for CalOptima-covered expenses incurred and paid during the time periods referenced in Section III.A. of this Policy. Excluded from the *Conlan* Adjudication Period are the time periods between mailing of a notice to a Member that additional information is required to process a claim, and receipt of such information, and any period during which a recoupment action is in effect against the Provider who owes a reimbursement.

IV. ATTACHMENT(S)

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F. Member Notice C: Claim Denial
G. Member Notice D: Direct Reimbursement from CalOptima to Member for Medi-Cal Rate
H. Member Notice E: Confirmation of Receipt of Claim

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy HH.1105Δ: Fraud and Abuse Detection
C. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
D. CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies
E. CalOptima Policy GG.1413: Polypharmacy Management
F. CalOptima Policy GG.1416: Pharmacy Home Program
G. CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
H. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy GG.1510: Appeal Process
K. Department of Health Care Services (DHCS) Notice to Medi-Cal beneficiaries
L. Department of Health Care Services (DHCS) Notice to Medi-Cal Rx: Post Transition roles & Responsibilities
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process
N. Title 22, California Code of Regulations (CCR), Section 51002

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	07/01/2009	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	03/01/2012	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	10/01/2016	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2017	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2018	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	05/01/2019	FF.2005	Conlan, Member Reimbursement	Medi-Cal
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IX. GLOSSARY

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Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Durable Medical Equipment (DME)	Any equipment, other than prosthetic or orthotic appliances, that is prescribed by a licensed Practitioner to meet the medical equipment needs of the Member that: 1. Can withstand repeated use; 2. Is used to serve a medical purpose; 3. Is not useful to a Member in the absence of an illness, injury, functional impairment or congenital anomaly; and 4. Is appropriate for use in or outside of the Member's home.
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Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

1

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number: _____

Dear Dr. NAME:

This letter is regarding a beneficiary reimbursement claim filed by a Medi-Cal beneficiary, (Beneficiary Name). He/She claims he/she was seen in your office on mm/dd/yy and mm/dd/yy and has provided documentation of his/her payment to you in the amount of $xxx.xx.

(Beneficiary Name) was eligible for Medi-Cal on the date(s) of service listed above. As a Medi-Cal provider, you are required to reimburse the beneficiary for the payments he/she made to you for the services. The beneficiary has reported that you have not made payment for the amount he/she paid you for the service(s).

In order to avoid an action by CalOptima to withhold these funds against future payments owed to you, you must immediately make payment to the beneficiary. The payment must be for the full amount made to you for the service(s). Once you have made payment to the beneficiary, you may submit a claim to CalOptima for reimbursement of these services. Reimbursement payment to the beneficiary should be mailed to:

Beneficiary Name
Beneficiary Address
Beneficiary Address

You must make payment to the beneficiary for the full amount of their out of pocket payment made to you. Failure to do this will result in CalOptima taking action to withhold the funds from future payments owed to you. If you have already made full payment to the beneficiary, or if you are in the process of sending this payment, please submit proof of payment with the attached Proof of Payment Form. This response should include the amount paid and the date it was paid. A response with your action must be received within 30 days from the date at the top of this letter. All correspondence should be sent to the following address:

CalOptima
Attn: Claims Administration
505 City Parkway West
Orange, CA 92868

Billing timeliness limitations for claims submissions (pursuant to Title 42 Code of Federal Regulations, section 447.45(d)(1) and California Code of Regulations (CCR), Title 22, Division 3, sections 51000.8(a) and 51008.5) will not apply due to good cause (pursuant to CCR, Title 22, Division 3, section 51008(a)) for the above claim for 60 days from the date of this letter. To request reimbursement from CalOptima for the services you provided, you must submit a claim within 60 days from the date of this letter. Submit an original claim and supporting documentation along with a copy of this letter to CalOptima Claims Administration at the address listed above.

You may disagree with this decision. If you do disagree and wish to dispute this claim, you may request a State Hearing. Information for a State Hearing is enclosed with this notice.

For more information on this matter, please call the Claims Customer Service Center at (714) 246-8885.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3.
Provider Notice A

PROOF OF PAYMENT FORM

Beneficiary Name
Beneficiary CIN Number
Provider Name

Please provide the following information to CalOptima as proof of payment to member/beneficiary for reimbursement of your services.

Proof of payment would be one of the following:

- Cash Receipt signed by patient
- Cancelled check showing payment to member/benficiary

Return this form with attachments and proof of payment to:

CalOptima
Attn: Claims Administration
505 City Parkway West
Orange, CA 92868

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

YOUR HEARING RIGHTS

You have a right to ask for a State Hearing about this Medi-Cal action. You must ask for a State Hearing within 30 days of the date this notice was mailed to you.

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

Beneficiary Service Center
P.O. Box 138008
Sacramento, CA 95813-8008

You have the right to examine the materials that were used to take this Medi-Cal action and may arrange this by contacting the Beneficiary Service Center at (916) 403-2007. For TDD service call (916) 635-6491.

STATE REGULATIONS AVAILABLE

State regulations, including those covering State Hearings, are available at your local county welfare office or on the Internet at www.calregs.com.

AUTHORIZED REPRESENTATIVE

You can represent yourself at the State Hearing. You must provide the name, address, and phone number of the person within your business entity that will represent you prior to the hearing. You can also be represented by an attorney. You must arrange for this representative yourself.

Note: The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete.

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

☐ I would like to request a State Hearing.

The reason I want a hearing is:_____
_____
_____
_____

☐ Check here and add a page if you need more space.

Provider's Name: (print)
_____
Provider's Nine Digit Medi-Cal Number:
_____
Provider's Business Address: (print)
_____
_____
Provider's Phone Number: (_____) _____
Beneficiary Reimbursement Reference No.
_____

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name:_____
Address:_____
_____

Phone number: (_____)_____

My signature (provider):

X_____

Date signed: _____

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number: _____

Dear Mr. NAME:

This letter is about a claim submitted by a Medi-Cal beneficiary, NAME. He/She claims to have been seen in your office on mm/dd/yy and mm/dd/yy. He/She has provided Medi-Cal with proof of his/her payment to you for those services in the amount of $xxx.xx.

NAME was eligible for Medi-Cal on the date(s) of service listed above. Medi-Cal reimburses enrolled medical providers for services rendered to Medi-Cal eligible beneficiaries. Medi-Cal eligible beneficiaries should not bear the burden of reimbursing providers for Medi-Cal covered services. Medi-Cal wants to pay you, the provider, for the services you rendered to NAME, allowing you to refund any payments made by NAME.

Our records show that you are not enrolled in the Medi-Cal Program. In order for CalOptima to pay for the services you provided, you need to enroll in the Medi-Cal program. Medi-Cal requests that you refund to NAME the amount of $**XXX.XX**, and upon enrollment in the Medi-Cal program, that you submit a claim to CalOptima for reimbursement for the services you provided. You can receive an enrollment application by calling the Telephone Service Center at 1-800-541-5555. Select options 15 and then 13. You can also download the application online at the Provider Enrollment page on the Medi-Cal Web site, www.Medi-Cal.ca.gov. When submitting your enrollment application, please include a copy of this letter on the very top of the application package. The enrollment application package must be submitted within 90 days of the date on the top of this notice in order for CalOptima to process the claim and reimburse you, the provider.

When enrolled, you may submit a claim for the above services with a copy of this letter within 90 days of the date on the notice that you have been enrolled, otherwise known as the Welcome to Medi-Cal letter. In order to avoid cutbacks in payment or denial due to the length of time since the service was provided, you must submit your claim within 90 days of the date of the Welcome to Medi-Cal letter and include a copy of this letter with the claim

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Reimbursement payment to the beneficiary should be mailed to:

Beneficiary Name
Beneficiary Address
Beneficiary Address

You may disagree with this decision or disagree with any of the facts of the claim. If you dispute any facts regarding the claim, please submit your dispute in writing, including any supporting documentation, along with a copy of this letter within 30 days of the date on this letter.

Please send proof of payment or a written dispute within 30 days of the date of this letter. If you wish to enroll as a provider in the Medi-Cal program and be reimbursed for these services, please send a notice of your desire to enroll in the Medi-Cal program within 30 days of this letter. Please include a copy of this letter with any correspondence you send.

Mail your desire to enroll as a provider in the Medi-Cal program to the following address:

Beneficiary Service Center
PO Box 138008
Sacramento, CA 95813-8008

Proof of payment or disputes may be mailed to the following address:

CalOptima OneCare
Attn: Claims Administration
505 City Parkway West
Orange, CA 92868

For more information on this matter, please call the Claims Customer Service Center at (714) 246-8885.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3.
Provider Notice B

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

YOUR HEARING RIGHTS

You have a right to ask for a State Hearing about this Medi-Cal action. You must ask for a State Hearing within 30 days of the date this notice was mailed to you.

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

Beneficiary Service Center
P.O. Box 138008
Sacramento, CA 95813-8008

You have the right to examine the materials that were used to take this Medi-Cal action and may arrange this by contacting the Beneficiary Service Center at (916) 403-2007. For TDD service call (916) 635-6491.

STATE REGULATIONS AVAILABLE

State regulations, including those covering State Hearings, are available at your local county welfare office or on the Internet at www.calregs.com.

AUTHORIZED REPRESENTATIVE

You can represent yourself at the State Hearing. You must provide the name, address, and phone number of the person within your business entity who will represent you prior to the hearing. You can also be represented by an attorney. You must arrange for this representative yourself.

Note: The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete.

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

☐ I would like to request a State Hearing.

The reason I want a hearing is:_____
_____
_____
_____

☐ Check here and add a page if you need more space.

Provider's Name: (print)
_____
Provider's Nine Digit Medi-Cal Number:
_____
Provider's Business Address: (print)
_____
_____
Provider's Phone Number: (_____) _____
Beneficiary Reimbursement Reference No.
_____

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name:_____
Address:_____
_____

Phone number: (_____)_____

My signature (provider):

X_____

Date signed: _____

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Provider Notice C

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number: _____

Dear Mr./Ms. NAME:

On [DATE OF FIRST NOTICE], CalOptima provided notice to you that it had received a beneficiary reimbursement claim from [MEMBER NAME], relative to the following dates of service: [DATE(S) OF SERVICE], in the amount of [CLAIM AMOUNT]. That notice also informed you that failure to pay would result in CalOptima recouping that amount from future payments owed to you by CalOptima, and of your rights to a State Hearing as to both the amount and the right of CalOptima to recoup those funds.

As of [DATE OF THIS LETTER], the period for filing a State Hearing has expired, and both the amount of the claim and CalOptima's right to recoup that amount if it remains unreimbursed to the Member will be presumed to be correct. You may avoid a recoupment action by CalOptima by providing proof of payment with the attached Proof of Payment Form, within fourteen (14) calendar days of the date of this letter. Failure to provide such proof of payment shall result in CalOptima setting off any amounts payable to you beginning on the date of this letter against the above claim amount until the full amount of the reimbursement claim has been obtained.

Please refer to the initial notice, attached for your reference, regarding where to send the reimbursement payments, and the timeliness requirements for claims to CalOptima relative to the services for which the Member reimbursement have been paid.

For more information on this matter, please call the Claims Customer Service Center at (714) 245-8669.

Sincerely,

[NAME]
[TITLE]

Enclosures
Previous Notice
Proof of Payment Form

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DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payment(s) you made for medical care. Medi-Cal forwarded your request to CalOptima for review. CalOptima administers Medi-Cal for Orange County.

[Provider Name] informed us that on MM/DD/YY they reimbursed you in the amount of $XXX.XX. Since that reimbursement payment resolved your claim, we closed your case.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

If you have any questions, please call CalOptima Customer Service at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3Member Notice A

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payment(s) you made for medical care. Medi-Cal forwarded your request to CalOptima for review. CalOptima administers Medi-Cal for Orange County.

CalOptima is not able to process your claim because required information is missing. We need the following information to process your claim:

- ☐ Proof of payment (such as a credit card receipt, cash receipt or cancelled check)
- ☐ Itemized bill from the health care provider that lists the services you received (the bill needs to list the specific billing codes)
- ☐ Name of health care provider who provided the services (the name is missing from the itemized bill)

Please send the needed information to:

CalOptima
Attn: Claims Administration
505 City Parkway West
Orange, CA 92868

CalOptima cannot process your claim until we receive the required information. We must receive the required information no later than 45 days from the date at the top of this letter, or we will deny your claim.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

If you have any questions, please call CalOptima Customer Service department at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3
Member Notice B

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payment(s) you made for medical care. Medi-Cal forwarded your request to CalOptima for review. CalOptima administers Medi-Cal for Orange County.

Your claim has been denied for the following reason(s):

- ☐ The member's claim is missing information. We requested this information but did not receive it within 45 days of the request.
- ☐ The member received services not covered by CalOptima at the time of service.
- ☐ The member received services when not eligible for reimbursement.
- ☐ The member received services when prior authorization was required but not obtained.
- ☐ The member received services out of network for non-emergency services.
- ☐ The member received services from a non-participating Medi-Cal provider.
- ☐ The member received services that do not comply with CalOptima's utilization protocols, policies and procedures as of the date of service.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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If you have any questions, please call CalOptima Customer service at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3
Member Notice C

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

Back to Agenda Back to Item

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payments you made for medical care. Medi-Cal sent your request to CalOptima for review.

Your claim has been modified. You asked Medi-Cal to reimburse you $XXX. The Medi-Cal rate for your medical service is $XXX. This is the maximum amount CalOptima will pay for this service.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

If you have any questions, please call CalOptima Customer service at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3
Member Notice D

Conlan Letter_Member Notice D

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payment(s) you made for medical care. Medi-Cal forwarded your request to CalOptima for review. CalOptima administers Medi-Cal for Orange County.

CalOptima has received your claim form and attachments. We will review your claim. If we need more information, we will send you a letter telling you what other information you need to send to us. If CalOptima needs more information, this may delay the processing of your claim.

After CalOptima reviews your claim, we will send you a written notice that tells you what CalOptima decided. We will mail that notice to you within 120 days after we received your claim.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

If you have any questions, please call CalOptima Customer service at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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Authority: Welfare and Institutions Code, Section 14019.3
Member Notice E

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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Policy:	FF.2011
Title:	~~Directed Payments~~Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	TBD
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~~and processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A and, as applicable, Attachment B of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) ~~approved preprint~~Approved Preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

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6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services ~~and~~, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and ~~Procedure Codes~~procedure codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, a Health Network shall further ensure that the VBP measures and the ICD-10 Codes reported are appropriate for the services being provided as well as any other data requested by CalOptima.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e~~.~~., Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

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

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Screening Service must be provided in accordance with the American Academy of Pediatrics~~/~~ (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

a. The following Developmental Screening Services are eligible for an Add-On Payment:
   i. A routine screening when provided:

      1) On or before the first birthday~~;~~ (twelve (12) months);

      2) After the first birthday and before or on the second birthday~~;~~ (twenty-four (24) months); or

      3) After the second birthday and on or before the third birthday~~.~~ (thirty-six (36) months).

   ii. Developmental Screening Services provided when ~~medically necessary~~Medically Necessary, in addition to routine screenings~~.~~, subject to the following conditions:

      1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

      2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

   i. The tool that was used to perform the Developmental Screening Service;

   ii. That the completed screen was reviewed;

   iii. The interpretation of results;

   iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

   v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of ~~the~~this Policy conflicts with the applicable requirements of DHCS guidance, CMS-~~approved preprint~~Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, a Health Network shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

a. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

b. Family Planning Services are not subject to any prior authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, a Health Network shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

a. An Add-On Payment for qualifying VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

i. Possess an individual (Type 1) National Provider Identifier (NPI); and

ii. Are practicing within their practice scope.

b. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, a Health Network shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, a Health Network shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

~~3.~~5. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs ~~screening services~~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.~~6. Abortion Services: For dates of service on or after July 1, ~~2018~~2017, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance ~~and~~or post-payment recovery, in accordance with its contractual obligations to CalOptima.

~~5.~~7. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

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~~from the date of service.

   a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

   b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

   a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

   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~~Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

c. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

d. 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~~report(s) in accordance with Section III.D. of this Policy.

a. ~~The~~Excluding the VBP Program, the CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

b. For the VBP Program, on a monthly basis, CalOptima's Quality Analytics Department shall provide a report to each Health Network via the secure file transfer protocol (sFTP).

i. The report will include at minimum, a list of:

1) Qualified providers that satisfy the requirements of Section III.A.4. of this Policy;

2) Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

3) Directed Payment amounts.

ii. CalOptima Quality Analytics Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to sending the report to the CalOptima Accounting Department to make a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit ~~a~~ Directed Payment adjustment report(s) for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit ~~an~~such adjustment report(s) in accordance with CalOptima's requirements and using CalOptima's proprietary format and file naming convention, as set forth in CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

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~~.~~; or

c. For the VBP Program, the Estimated Initial Month Payment shall be based upon data provided by CalOptima Quality Analytics Department to CalOptima Accounting Department.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

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~~procedure code, service month~~, payor~~ and year, program-specific measures, payer (*i.e.*, the Member's Health Network~~, or its delegated entity or subcontractor~~ that is financially responsible for the specified Directed Payment,), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

    a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

    b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised ~~05~~07/01/2020)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
~~G.~~H. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
~~H.~~I. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
~~I.~~J. 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.~~K. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
~~K.~~L. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
~~L.~~M. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
~~M.~~N. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
~~N.~~O. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

P. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
Q. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
R. Proposition 56 Value-Based Payment Program Measure Valuation Summary

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
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal
Revised	05/01/2020	FF.2011	Directed Payments	Medi-Cal
Revised	TBD	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal

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 & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangements for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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~~notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California 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~~Developmental Screening Services, and VBP Program Services; 2. Eligible Contracted Providers and non-contracted Providers that are ~~FQHCs, RHCs, and Indian Health~~Family Planning Providers for Family Planning Services ~~Memorandum of Agreement (IHS-MOA) 638 clinics~~; ~~2.~~3. Eligible Contracted Providers and non-contracted Providers for ~~Developmental Screening~~Abortion Services; and ~~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.

Term	Definition
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as set forth in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	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.

Term	Definition
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Term	Definition
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

Policy:	FF.2011
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which a Health Network shall administer the Directed Payments for Qualifying Services, and processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A and, as applicable, Attachment B of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) Approved Preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

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6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, a Health Network shall further ensure that the VBP measures and the ICD-10 Codes reported are appropriate for the services being provided as well as any other data requested by CalOptima.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e., Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

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 rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright

Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

a. The following Developmental Screening Services are eligible for an Add-On Payment:
   i. A routine screening when provided:

      1) On or before the first birthday (twelve (12) months);

      2) After the first birthday and before or on the second birthday (twenty-four (24) months); or

      3) After the second birthday and on or before the third birthday (thirty-six (36) months).

   ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

      1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

      2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

b. Development Screening Services are not subject to any prior authorization requirements.

c. 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 this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, a Health Network shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

   a. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

   b. Family Planning Services are not subject to any prior authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, a Health Network shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

   a. An Add-On Payment for qualifying VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

      i. Possess an individual (Type 1) National Provider Identifier (NPI); and

      ii. Are practicing within their practice scope.

   b. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

   c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, a Health Network shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, a Health Network shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

5. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

      ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

      iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and

self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance or post-payment recovery, in accordance with its contractual obligations to CalOptima.

7. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year from the date of service.

   a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

   b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

   a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

   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 Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

c. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

d. 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 report(s) in accordance with Section III.D. of this Policy.

a. Excluding the VBP Program, the CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

b. For the VBP Program, on a monthly basis, CalOptima's Quality Analytics Department shall provide a report to each Health Network via the secure file transfer protocol (sFTP).

i. The report will include at minimum, a list of:

1) Qualified providers that satisfy the requirements of Section III.A.4. of this Policy;

2) Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

3) Directed Payment amounts.

ii. CalOptima Quality Analytics Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to sending the report to the CalOptima Accounting Department to make a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit Directed Payment adjustment report(s) for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit such adjustment report(s) in accordance with CalOptima's requirements and using CalOptima's proprietary format and file naming convention, as set forth in CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network

shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims;

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services; or

   c. For the VBP Program, the Estimated Initial Month Payment shall be based upon data provided by CalOptima Quality Analytics Department to CalOptima Accounting Department.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (*i.e.*, the Member's Health Network that is financially responsible for the specified Directed Payment,), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

    a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

    b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised 07/01/2020)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
H. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
I. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
J. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
K. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
M. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
N. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
O. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

P. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
Q. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
R. Proposition 56 Value-Based Payment Program Measure Valuation Summary

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
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal
Revised	05/01/2020	FF.2011	Directed Payments	Medi-Cal
Revised	TBD	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal

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 & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangements for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (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.
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, Developmental Screening Services, and VBP Program Services; 2. Eligible Contracted Providers and non-contracted Providers that are Family Planning Providers for Family Planning Services; 3. Eligible Contracted Providers and non-contracted Providers for Abortion Services; and 4. Non-contracted GEMT Providers for GEMT 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.

Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as set forth in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	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.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]*At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.*

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[3]~~ Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

~~[3]Payment~~ [4]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[4]~~Payment[5]
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

~~[4]Payment~~[5]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[6]	
		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

[6]*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.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

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Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]*At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[4]Payment obligations for rates of at least $29 for eligible service codes

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[5]
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

[5]*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[6]	
		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

[6]*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.

The Department of Health Care Services (DHCS) is providing the measure specifications for the Value-Based Payment (VBP) Program measures. DHCS may make technical updates to VBP measure specifications as needed and appropriate to reflect recommended clinical practice, current coding standards, and/or changes in Centers for Medicare and Medicaid (CMS) Core Set measure specifications.

Contents

Prenatal/Postpartum Care

Prenatal Pertussis ('Whooping Cough') Vaccine

Incentive payment to the provider for the administration of the pertussis vaccination to women who are pregnant

- Payment to rendering or prescribing provider for Tdap vaccine (CPT 90715) with an ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) anytime in the measurement year
- Payment may only occur once per delivery per patient
- Multiple births: Women who had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may count twice

This measure supports the Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Immunization Status measure. The measure looks at the percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Prenatal Care Visit

Incentive payment to the provider for ensuring that the woman comes in for her initial prenatal visit

- Payment to rendering provider for provision of prenatal and preventive care on a routine, outpatient basis - not intended for emergent events
- No more than one payment per pregnancy per plan
- Payment for the first visit in a plan that is for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) with a 992xx CPT code on the encounter

DHCS understands that women may change providers and plans during a pregnancy. Therefore, the first visit that occurs in a specific plan will be paid. The intent is to encourage that visit to happen quickly to begin the prenatal relationship.

This measure supports the Centers for Medicare and Medicaid (CMS) Child Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH). The Measure PPC-CH measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/Children's Health Insurance Program (CHIP).

Postpartum Care Visits

Incentive payment for completion of recommended postpartum care visits after a woman gives birth

- Payment to rendering provider for provision of an Early Postpartum Visit (a postpartum visit on or between 1 and 21 days after delivery)
- Payment to rendering provider for provision of a Late Postpartum Visit (a postpartum visit on or between 22 and 84 days after delivery)
- Payment to the first visit in the time period (Early or Late)
- No more than one payment per time period (Early or Late)
- Postnatal visit is identified for this purpose by the use of the ICD-10 code for postpartum visit (Z39.2) on the encounter

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

Definitions

Early Postpartum Visit	A postpartum visit on or between 1 and 21 days after delivery
Late Postpartum Visit	A postpartum visit on or between 22 and 84 days after delivery

Incentive payments support the current American College of Obstetricians and Gynecologists recommendations regarding the two postpartum visits. DHCS expects that nationally utilized quality metrics will eventually align with the current clinical recommendations. The current CMS Adult Core Set Prenatal and Postpartum Care: Postpartum Care (PPC-AD) measure is expected to align with this in the future. The current Measure PPC-AD measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Postpartum Birth Control

Incentive payment to provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery

- Payment to rendering or prescribing provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery
- Payment to the first occurrence of contraception in the time period
- No more than one payment per delivery

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

The codes used to calculate this measure are available in Tables CCP-C through CCPD at:

https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-ofcare%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip

This measure supports CMS Child and Adult Core Set Measures Contraceptive Care - Postpartum Measures (CCP-CH) (ages 15-20) and (CCP-AD) (ages 21-44) The Measure CCP measures among women who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Early Childhood

Well Child Visits in First 15 Months of Life

Separate incentive payment to a provider for each of the last three well child visits out of eight total - 6th, 7th and 8th visits. (Eight visits are recommended between birth and 15 months)

- Separate payment to each rendering provider for successfully completing each of the three well child visits at the following times:
  - 6 month visit – the first well care visit between 172 and 263 days of life
  - 9 month visit – the first well care visit between 264 and 355 days of life
  - 12 month visit – the first well care visit between 356 and 447 days of life
- Three payments per child are eligible for payment • Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439
  - ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the First 15 Months of Life (W15-CH). The Measure W15-CH measures the percentage of children who turned 15 months old during the measurement year and who had six or more wellchild visits with a primary care practitioner during their first 15 months of life.

Well Child Visits in 3rd – 6th Years of Life

Separate payment to each rendering provider for successfully completing each of the annual well child visits at age 3, 4, 5, and 6

- Payment for the first well child visit in each year age group (3, 4, 5, or 6 year olds)
- Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439

- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH). The Measure W34-CH measures the percentage of children ages three to six who had one or more well-child visits with a primary care practitioner during measurement year.

All Childhood Vaccines for Two Year Olds

For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given on or before the second birthday

- Payment to each rendering provider for each final vaccine administered in a series to children turning age two in the measurement year:
  - Diphtheria, tetanus, pertussis (DTaP) – 4th vaccine
  - Inactivated Polio Vaccine (IPV) – 3rd vaccine
  - Hepatitis B – 3rd vaccine
  - Haemophilus Influenzae Type b (Hib) – 3rd vaccine
  - Pneumococcal conjugate – 4th vaccine
  - Rotavirus – 2nd or 3rd vaccine
  - Flu – 2nd vaccine
- A given provider may receive up to seven payments per year per patient
- A two year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series

This measure supports the CMS Child Core Set Childhood Immunization Status (CISCH). The Measure CIS-CH measures the percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Blood Lead Screening

Incentive payment to a provider for completing a blood lead screening in children up to two years of age

- Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday
- Provider can receive more than one payment

Blood lead tests will not be excluded if a child is diagnosed with lead toxicity.

This measure supports the HEDIS measure Lead Screening in Children (LSC). The LSC measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Dental Fluoride Varnish

Incentive payment to provider if provides oral fluoride varnish application for children 6 months through 5 years

- Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six
- Payment for the first four visits in a 12 month period

Chronic Disease Management

Controlling High Blood Pressure

Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years old being seen by the provider for their diagnosis of high blood pressure

- Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents controlled blood pressure
- A visit for controlled blood pressure must include a code for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension on the same day • Ages 18 to 85 at the time of the visit

Codes for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension are:

- Controlled Systolic:
  - CPT 3074F (systolic blood pressure less than 130) – CPT 3075F (systolic blood pressure less than 130-39)
- Controlled Diastolic:
  - CPT 3078F (diastolic blood pressure less than 80) – CPT 3079F (diastolic blood pressure less than 80-89)
- Hypertension:
  - ICD-10: I10 (essential hypertension)

This measure supports CMS Adult Core Set Controlling High Blood Pressure (CBP-AD). The measure CBP-AD measures the percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Diabetes Care

Incentive payment to provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that shows the results of the test for members 18 to 75 years of age

- Payment to each rendering provider for each event of diabetes (HbA1c) testing (laboratory or point of care testing) that shows the results for members 18 to 75 years as coded with:
  - CPT 3044F most recent HbA1c < 7.0%
  - CPT 3045F most recent HbA1c 7.0-9.0% (through September 30, 2019)
  - CPT 3051F most recent HbA1c >= 7.0% and < 8.0% (as of October 1, 2019)

  - CPT 3052F most recent HbA1c 8.0-9.0% (as of October 1, 2019)
  - CPT 3046F most recent HbA1c > 9.0%
- No more than four payments per year.
- Dates for HbA1c results must be at least 60 days apart.
- Diabetes diagnosis is not required to allow for screening of individuals at increased risk of diabetes.

This measure supports both CMS Adult Core Set measures HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (HPC-AD) The measure HA1C-AD assesses the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test, and the measure HPC-AD measures the percentage with an HbA1c level <9.0%.

Control of Persistent Asthma

Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications

- Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based on the Asthma Value Set, in the measurement year or the year prior to the measurement year
- Each provider is paid once per year per patient
- Ages 5 to 64 at the time of the visit

The Asthma Value Set includes the following diagnosis codes:

J45.20 Mild intermittent asthma, uncomplicated
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus
J45.30 Mild persistent asthma, uncomplicated
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus J45.909 Unspecified asthma, uncomplicated
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma

This measure specification supports CMS Child and Adult Core Set measures Asthma Medication Ratio: Ages 5-18 (AMR-CH) and Ages 19-64 (AMR-AD). These measures assess the percentage of beneficiaries ages 5-64 who were identified as having

persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater.

Tobacco Use Screening

Incentive payment to provider for tobacco use screening or counseling provided to members 12 years and older

- Payment to rendering provider for any of the following CPT codes: 99406, 99407, 4004F, or 1036F (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco.

This measure aligns with U.S. Preventive Services Task Force (USPFTF) recommendations with regards to screening/counseling for tobacco

- Adults: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
- Adolescents: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions

Adult Influenza ('Flu') Vaccine

Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older

- Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 and older at the time of the flu shot
- No more than one payment per patient per quarter for the first quarter of the year (January through March) or the last quarter of the year (October through December)
- If more than one provider gives the shot in the quarter only the first provider gets paid in that quarter

This measures supports the American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI) NQF 0041 Preventive Care and Screening: Influenza Immunization which assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization.

Screening for Clinical Depression

Incentive payment to provider for conducting screening for clinical depression (using a standardized screening tool) for beneficiaries 12 years and older

- Payment to rendering provider for any of the following CPT codes for screening for clinical depression: G8431 or G8510 (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports CMS Core Set measure Screening for Depression and Followup Plan: Age 18 and Older (CDF-AD). The measure CDF-AD assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Management of Depression Medication

Incentive payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and newly treated with an anti-depressant medication who has remained on the anti-depressant medication for at least 12 weeks

- Payment to prescribing providers for the Effective Acute Phase Treatment for patients 18 years and older with a diagnosis of major depression 60 days before the new prescription through 60 days after
- Effective Acute Phase Treatment is at least 84 days during 12 weeks of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days)
- Payment to each prescribing provider that prescribed antidepressant medications during Effective Acute Phase Treatment period
- No more than one Effective Acute Phase Treatment per year

Definitions

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative medication history	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	At least 84 days of treatment beginning on the IPSD through 114 days after the IPSD.
Major depression diagnosis codes	ICD10: F32.0,F32.1,F32.2,F32.3,F32.4,F32.9,F33.0, F33.1,F33.2,F33.3,F33.41,F33.9

Antidepressant medication	NCQA's Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndclicense/hedis-2019-final-ndc-lists/.

This measure supports the CMS Adult Core Set measure Antidepressant Medication Management (AMM-AD). The Measure AMM-AD Effective Acute Phase Treatment measures the percentage of beneficiaries age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication for at least 84 days (12 weeks).

Screening for Unhealthy Alcohol Use

Incentive payment to provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older

- Payment to rendering provider for any of the following CPT codes: 99408, 99409, G0396, G0397, G0442, G0443, H0049, or H0050 (equivalent payment for all codes)
- No more than one payment per provider per patient per year

This measure specification supports Quality Identifier #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. The Measure NQF 2152 measures the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.

The measures aligns with USPFTF Recommendations with regards to alcohol screening tools:

- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioralcounseling-interventions

Overarching Payment Conditions

Data to be used to calculate payments:

- Medi-Cal administrative data reported through the Managed Care Plans encounter data
- Medi-Cal administrative data reported in the Medi-Cal Eligibility Data System
- For measures involving immunizations, the expectation is that immunizations reported through the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 will be used as a supplementary data source
- For the Blood Lead Screening measure, the expectation is that blood lead test results reported through the CDPH Blood Lead Registry may be used as a supplementary data source

Providers will be identified based on:

- National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1)
- If the rendering or ordering is not filled, then look for prescribing provider field that is an NPI for an individual (Type 1)
- If the rendering, ordering, or prescribing is not filled, then look for billing provider that is an NPI for an individual (Type 1)
- To qualify for payment, providers must be practicing within their practice scope and must have an individual (Type 1) NPI. For example, if a pharmacist (not the pharmacy) provides an immunization, then that pharmacist could receive payment.

Beneficiary inclusion criteria:

- Services for beneficiaries with Medicare Part B will be excluded
- Payments are based on Medi-Cal having the encounter data

Beneficiary exclusion criteria:

- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics, and Cost Based Reimbursement Clinics will be excluded from payment

An enhanced payment factor will be applied to the above services provided to beneficiaries with the following conditions:

- Substance Use Disorder (SUD) – CMS Core Set Measure Set: AOD Abuse and Dependence Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Serious Mental Illness (SMI) – CMS Core Set Measure Sets: Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set, and Major Depression Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Homeless ICD-10 Diagnosis code with the following values:
  - Z59.0 Homeless
  - Z59.1 Inadequate Housing

The SUD and SMI at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the measurement year. The diagnosis of homeless should be on the encounter data for the VBP eligible service.

Post utilization monitoring will be performed to ensure overuse of services is not occurring.

Technical Updates to the Specifications

Updated in May 7, 2020 Version:

- Removed from the Diabetes measure the reference to the Hemoglobin A1c (HA1C-AD) Testing measure, which was removed from the CMS Adult Core Set in the 2020 reporting year (data collection year 2019).
- Adjusted the Diabetes measure to indicate CPT 3045F is valid through September 30, 2019 and is replaced with CPT 3051F and CPT 3052F as of October 1, 2019.
- Removed from the Tobacco Use Screening measure codes CPT G0436 and CPT G0437, which were retired September 30, 2016.
- Added to the Screening for Unhealthy Alcohol Use measure codes CPT G0442 and CPT G0443.

Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	06/04/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

3. The Designated Provider was eligible to receive the Directed Payment.

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4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A and, as applicable, Attachment B of this Policy:

1. An Add-On Payment for Physician Services ~~and~~, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

E. CalOptima shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and ~~Procedure Codes~~procedure codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, CalOptima shall further ensure that the VBP measures and ICD-10 Codes reported are appropriate for the services being provided.

F. CalOptima shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. For CalOptima Direct, how to file a grievance and second level appeal with CalOptima. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima.

H. CalOptima Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint and/or FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, as applicable.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), 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, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers ~~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~~/~~ (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday~~;~~ (twelve (12) months);

         2) After the first birthday and before or on the second birthday~~;~~ (twenty-four (24) months); or

         3) After the second birthday and on or before the third birthday~~.~~ (thirty-six (36) months).

      ii. ~~ii.~~ Developmental Screening Services provided when ~~Medically Necessary~~Medically Necessary, in addition to routine screenings~~.~~, subject to the following conditions:

         1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

         2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

   b. Development Screening Services are not subject to any Prior Authorization requirements.

   c. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

   d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

      i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;
iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, CalOptima shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

a. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

b. Family Planning Services are not subject to any Prior Authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, CalOptima shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

a. An Add-On Payment for VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

i. Possess an individual (Type 1) National Provider Identifier (NPI); and

ii. Are practicing within their practice scope.

b. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, CalOptima shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, CalOptima shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

d. CalOptima's Quality Analytics Department shall develop a monthly report to process payments which will include, at minimum, a list of:

i. Eligible Contracted Providers that satisfy the requirements of this Section III.A.4 of the Policy;

ii. Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

iii. Add-On Payment amount(s).

~~3.~~5. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. CalOptima shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima and/or DHCS upon request.

~~4.~~6. Abortion Services: For dates of service on or after July 1, 2017, CalOptima shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

~~5.~~7. GEMT Services: For dates of service on or after July 1, 2018, CalOptima shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. CalOptima shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

b. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by CalOptima with specified dates of service (i.e., between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), CalOptima shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, CalOptima shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by CalOptima no later than one (1) year from the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.
b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima shall:

1. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

2. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima to the GEMT Provider; or

iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Provider, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

1. CalOptima shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Policy FF.2011: Directed Payments, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by DHCS, including an attestation confirming the completion of the report. Reports shall include CalOptima's Health Care Plan Code, as well as CPT, HCPCS, or ~~Procedure Code~~procedure code, service month and year, program-specific measures, payer (e.g., CalOptima or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

    a. CalOptima shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima must submit an attestation to DHCS stating that no updated information is available.

    b. If updated information is available for the quarterly report, CalOptima must submit the updated quarterly report in the appropriate file format and include an attestation that CalOptima considers the report complete.

2. CalOptima shall continue to submit encounter data for the Directed Payments as required by DHCS.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised 07/01/2020)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Medi-Cal Glossary of Terms
C. 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 FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
G. CalOptima Policy FF.2003: Coordination of Benefits
H. CalOptima Policy FF.2011: Directed Payments
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1116: Pediatric Preventive Services
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
M. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
N. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
P. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19

R. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services

T. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
U. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
V. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
W. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
X. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
Y. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	TBD	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare ~~and~~& Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.

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 notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, ~~and Abortion~~Developmental Screening Services, and VBP Program Services; 2. Eligible Contracted Providers and non-contracted Providers that are ~~FQHCs, RHCs, and Indian Health~~Family Planning Providers for Family Planning Services ~~Memorandum of Agreement (IHS-MOA) 638 clinics~~; ~~2.~~3. Eligible Contracted Providers and non-contracted Providers for ~~Developmental Screening~~Abortion Services; and ~~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.

Term	Definition
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as specified in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	For purposes of this Policy, 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.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to CalOptima Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Term	Definition
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	06/04/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

3. The Designated Provider was eligible to receive the Directed Payment.

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4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A and, as applicable, Attachment B of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

E. CalOptima shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, CalOptima shall further ensure that the VBP measures and ICD-10 Codes reported are appropriate for the services being provided.

F. CalOptima shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. For CalOptima Direct, how to file a grievance and second level appeal with CalOptima. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima.

H. CalOptima Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint and/or FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, as applicable.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), 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, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday (twelve (12) months);

         2) After the first birthday and before or on the second birthday (twenty-four (24) months); or

         3) After the second birthday and on or before the third birthday (thirty-six (36) months).

      ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

         1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

         2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

   b. Development Screening Services are not subject to any Prior Authorization requirements.

   c. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

   d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

      i. The tool that was used to perform the Developmental Screening Service;

      ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, CalOptima shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

a. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

b. Family Planning Services are not subject to any Prior Authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, CalOptima shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

a. An Add-On Payment for VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

i. Possess an individual (Type 1) National Provider Identifier (NPI); and

ii. Are practicing within their practice scope.

b. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, CalOptima shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, CalOptima shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

d. CalOptima's Quality Analytics Department shall develop a monthly report to process payments which will include, at minimum, a list of:

i. Eligible Contracted Providers that satisfy the requirements of this Section III.A.4 of the Policy;

ii. Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

iii. Add-On Payment amount(s).

5. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

      ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

      iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

   b. CalOptima shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

      i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

      ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

   c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

      i. The tool that was used to perform the ACEs Screening Service;

      ii. That the completed screen was reviewed;

      iii. The interpretation of results;

      iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

      v. Any appropriate actions taken.

   d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, CalOptima shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified

to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

7. GEMT Services: For dates of service on or after July 1, 2018, CalOptima shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. CalOptima shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

b. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by CalOptima with specified dates of service (i.e., between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), CalOptima shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, CalOptima shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by CalOptima no later than one (1) year from the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima shall:

   1. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

   2. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

   a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

      i. The Member has other sources of health coverage;

      ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

      iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima to the GEMT Provider; or

      iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Provider, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

1. CalOptima shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Policy FF.2011: Directed Payments, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by

DHCS, including an attestation confirming the completion of the report. Reports shall include CalOptima's Health Care Plan Code, as well as CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (e.g., CalOptima or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

a. CalOptima shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima must submit an attestation to DHCS stating that no updated information is available.

b. If updated information is available for the quarterly report, CalOptima must submit the updated quarterly report in the appropriate file format and include an attestation that CalOptima considers the report complete.

2. CalOptima shall continue to submit encounter data for the Directed Payments as required by DHCS.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised 07/01/2020)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Medi-Cal Glossary of Terms
C. 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 FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
G. CalOptima Policy FF.2003: Coordination of Benefits
H. CalOptima Policy FF.2011: Directed Payments
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1116: Pediatric Preventive Services
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
M. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
N. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
P. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-015: Proposition 56

Physicians Directed Payments for Specified Services

T. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
U. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
V. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
W. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
X. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
Y. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	TBD	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (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.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, Developmental Screening Services, and VBP Program Services; 2. Eligible Contracted Providers and non-contracted Providers that are Family Planning Providers for Family Planning Services; 3. Eligible Contracted Providers and non-contracted Providers for Abortion Services; and 4. Non-contracted GEMT Providers for GEMT 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.

Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as specified in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	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	For purposes of this Policy, specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to CalOptima Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Term	Definition
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.

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[3]~~ Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

~~[3]Payment~~ [4]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[4]~~Payment[5]
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

~~[4]Payment~~[5]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[6]	
		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

[6]*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.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

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Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.

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Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[4]Payment obligations for rates of at least $29 for eligible service codes

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[5]
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

[5]*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[6]	
		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

[6]*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.

The Department of Health Care Services (DHCS) is providing the measure specifications for the Value-Based Payment (VBP) Program measures. DHCS may make technical updates to VBP measure specifications as needed and appropriate to reflect recommended clinical practice, current coding standards, and/or changes in Centers for Medicare and Medicaid (CMS) Core Set measure specifications.

Contents

Prenatal/Postpartum Care

Prenatal Pertussis ('Whooping Cough') Vaccine

Incentive payment to the provider for the administration of the pertussis vaccination to women who are pregnant

- Payment to rendering or prescribing provider for Tdap vaccine (CPT 90715) with an ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) anytime in the measurement year
- Payment may only occur once per delivery per patient
- Multiple births: Women who had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may count twice

This measure supports the Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Immunization Status measure. The measure looks at the percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Prenatal Care Visit

Incentive payment to the provider for ensuring that the woman comes in for her initial prenatal visit

- Payment to rendering provider for provision of prenatal and preventive care on a routine, outpatient basis - not intended for emergent events
- No more than one payment per pregnancy per plan
- Payment for the first visit in a plan that is for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) with a 992xx CPT code on the encounter

DHCS understands that women may change providers and plans during a pregnancy. Therefore, the first visit that occurs in a specific plan will be paid. The intent is to encourage that visit to happen quickly to begin the prenatal relationship.

This measure supports the Centers for Medicare and Medicaid (CMS) Child Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH). The Measure PPC-CH measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/Children's Health Insurance Program (CHIP).

Postpartum Care Visits

Incentive payment for completion of recommended postpartum care visits after a woman gives birth

- Payment to rendering provider for provision of an Early Postpartum Visit (a postpartum visit on or between 1 and 21 days after delivery)
- Payment to rendering provider for provision of a Late Postpartum Visit (a postpartum visit on or between 22 and 84 days after delivery)
- Payment to the first visit in the time period (Early or Late)
- No more than one payment per time period (Early or Late)
- Postnatal visit is identified for this purpose by the use of the ICD-10 code for postpartum visit (Z39.2) on the encounter

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

Definitions

Early Postpartum Visit	A postpartum visit on or between 1 and 21 days after delivery
Late Postpartum Visit	A postpartum visit on or between 22 and 84 days after delivery

Incentive payments support the current American College of Obstetricians and Gynecologists recommendations regarding the two postpartum visits. DHCS expects that nationally utilized quality metrics will eventually align with the current clinical recommendations. The current CMS Adult Core Set Prenatal and Postpartum Care: Postpartum Care (PPC-AD) measure is expected to align with this in the future. The current Measure PPC-AD measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Postpartum Birth Control

Incentive payment to provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery

- Payment to rendering or prescribing provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery
- Payment to the first occurrence of contraception in the time period
- No more than one payment per delivery

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

The codes used to calculate this measure are available in Tables CCP-C through CCPD at:

https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-ofcare%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip

This measure supports CMS Child and Adult Core Set Measures Contraceptive Care - Postpartum Measures (CCP-CH) (ages 15-20) and (CCP-AD) (ages 21-44) The Measure CCP measures among women who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Early Childhood

Well Child Visits in First 15 Months of Life

Separate incentive payment to a provider for each of the last three well child visits out of eight total - 6th, 7th and 8th visits. (Eight visits are recommended between birth and 15 months)

- Separate payment to each rendering provider for successfully completing each of the three well child visits at the following times:
  - 6 month visit – the first well care visit between 172 and 263 days of life
  - 9 month visit – the first well care visit between 264 and 355 days of life
  - 12 month visit – the first well care visit between 356 and 447 days of life
- Three payments per child are eligible for payment • Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439
  - ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the First 15 Months of Life (W15-CH). The Measure W15-CH measures the percentage of children who turned 15 months old during the measurement year and who had six or more wellchild visits with a primary care practitioner during their first 15 months of life.

Well Child Visits in 3rd – 6th Years of Life

Separate payment to each rendering provider for successfully completing each of the annual well child visits at age 3, 4, 5, and 6

- Payment for the first well child visit in each year age group (3, 4, 5, or 6 year olds)
- Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439

- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH). The Measure W34-CH measures the percentage of children ages three to six who had one or more well-child visits with a primary care practitioner during measurement year.

All Childhood Vaccines for Two Year Olds

For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given on or before the second birthday

- Payment to each rendering provider for each final vaccine administered in a series to children turning age two in the measurement year:
  - Diphtheria, tetanus, pertussis (DTaP) – 4th vaccine
  - Inactivated Polio Vaccine (IPV) – 3rd vaccine
  - Hepatitis B – 3rd vaccine
  - Haemophilus Influenzae Type b (Hib) – 3rd vaccine
  - Pneumococcal conjugate – 4th vaccine
  - Rotavirus – 2nd or 3rd vaccine
  - Flu – 2nd vaccine
- A given provider may receive up to seven payments per year per patient
- A two year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series

This measure supports the CMS Child Core Set Childhood Immunization Status (CISCH). The Measure CIS-CH measures the percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Blood Lead Screening

Incentive payment to a provider for completing a blood lead screening in children up to two years of age

- Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday
- Provider can receive more than one payment

Blood lead tests will not be excluded if a child is diagnosed with lead toxicity.

This measure supports the HEDIS measure Lead Screening in Children (LSC). The LSC measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Dental Fluoride Varnish

Incentive payment to provider if provides oral fluoride varnish application for children 6 months through 5 years

- Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six
- Payment for the first four visits in a 12 month period

Chronic Disease Management

Controlling High Blood Pressure

Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years old being seen by the provider for their diagnosis of high blood pressure

- Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents controlled blood pressure
- A visit for controlled blood pressure must include a code for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension on the same day • Ages 18 to 85 at the time of the visit

Codes for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension are:

- Controlled Systolic:
  - CPT 3074F (systolic blood pressure less than 130) – CPT 3075F (systolic blood pressure less than 130-39)
- Controlled Diastolic:
  - CPT 3078F (diastolic blood pressure less than 80) – CPT 3079F (diastolic blood pressure less than 80-89)
- Hypertension:
  - ICD-10: I10 (essential hypertension)

This measure supports CMS Adult Core Set Controlling High Blood Pressure (CBP-AD). The measure CBP-AD measures the percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Diabetes Care

Incentive payment to provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that shows the results of the test for members 18 to 75 years of age

- Payment to each rendering provider for each event of diabetes (HbA1c) testing (laboratory or point of care testing) that shows the results for members 18 to 75 years as coded with:
  - CPT 3044F most recent HbA1c < 7.0%
  - CPT 3045F most recent HbA1c 7.0-9.0% (through September 30, 2019)
  - CPT 3051F most recent HbA1c >= 7.0% and < 8.0% (as of October 1, 2019)

  - CPT 3052F most recent HbA1c 8.0-9.0% (as of October 1, 2019)
  - CPT 3046F most recent HbA1c > 9.0%
- No more than four payments per year.
- Dates for HbA1c results must be at least 60 days apart.
- Diabetes diagnosis is not required to allow for screening of individuals at increased risk of diabetes.

This measure supports both CMS Adult Core Set measures HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (HPC-AD) The measure HA1C-AD assesses the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test, and the measure HPC-AD measures the percentage with an HbA1c level <9.0%.

Control of Persistent Asthma

Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications

- Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based on the Asthma Value Set, in the measurement year or the year prior to the measurement year
- Each provider is paid once per year per patient
- Ages 5 to 64 at the time of the visit

The Asthma Value Set includes the following diagnosis codes:

J45.20 Mild intermittent asthma, uncomplicated
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus
J45.30 Mild persistent asthma, uncomplicated
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus J45.909 Unspecified asthma, uncomplicated
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma

This measure specification supports CMS Child and Adult Core Set measures Asthma Medication Ratio: Ages 5-18 (AMR-CH) and Ages 19-64 (AMR-AD). These measures assess the percentage of beneficiaries ages 5-64 who were identified as having

persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater.

Tobacco Use Screening

Incentive payment to provider for tobacco use screening or counseling provided to members 12 years and older

- Payment to rendering provider for any of the following CPT codes: 99406, 99407, 4004F, or 1036F (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco.

This measure aligns with U.S. Preventive Services Task Force (USPFTF) recommendations with regards to screening/counseling for tobacco

- Adults: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
- Adolescents: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions

Adult Influenza ('Flu') Vaccine

Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older

- Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 and older at the time of the flu shot
- No more than one payment per patient per quarter for the first quarter of the year (January through March) or the last quarter of the year (October through December)
- If more than one provider gives the shot in the quarter only the first provider gets paid in that quarter

This measures supports the American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI) NQF 0041 Preventive Care and Screening: Influenza Immunization which assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization.

Screening for Clinical Depression

Incentive payment to provider for conducting screening for clinical depression (using a standardized screening tool) for beneficiaries 12 years and older

- Payment to rendering provider for any of the following CPT codes for screening for clinical depression: G8431 or G8510 (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports CMS Core Set measure Screening for Depression and Followup Plan: Age 18 and Older (CDF-AD). The measure CDF-AD assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Management of Depression Medication

Incentive payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and newly treated with an anti-depressant medication who has remained on the anti-depressant medication for at least 12 weeks

- Payment to prescribing providers for the Effective Acute Phase Treatment for patients 18 years and older with a diagnosis of major depression 60 days before the new prescription through 60 days after
- Effective Acute Phase Treatment is at least 84 days during 12 weeks of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days)
- Payment to each prescribing provider that prescribed antidepressant medications during Effective Acute Phase Treatment period
- No more than one Effective Acute Phase Treatment per year

Definitions

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative medication history	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	At least 84 days of treatment beginning on the IPSD through 114 days after the IPSD.
Major depression diagnosis codes	ICD10: F32.0,F32.1,F32.2,F32.3,F32.4,F32.9,F33.0, F33.1,F33.2,F33.3,F33.41,F33.9

Antidepressant medication	NCQA's Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndclicense/hedis-2019-final-ndc-lists/.

This measure supports the CMS Adult Core Set measure Antidepressant Medication Management (AMM-AD). The Measure AMM-AD Effective Acute Phase Treatment measures the percentage of beneficiaries age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication for at least 84 days (12 weeks).

Screening for Unhealthy Alcohol Use

Incentive payment to provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older

- Payment to rendering provider for any of the following CPT codes: 99408, 99409, G0396, G0397, G0442, G0443, H0049, or H0050 (equivalent payment for all codes)
- No more than one payment per provider per patient per year

This measure specification supports Quality Identifier #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. The Measure NQF 2152 measures the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.

The measures aligns with USPFTF Recommendations with regards to alcohol screening tools:

- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioralcounseling-interventions

Overarching Payment Conditions

Data to be used to calculate payments:

- Medi-Cal administrative data reported through the Managed Care Plans encounter data
- Medi-Cal administrative data reported in the Medi-Cal Eligibility Data System
- For measures involving immunizations, the expectation is that immunizations reported through the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 will be used as a supplementary data source
- For the Blood Lead Screening measure, the expectation is that blood lead test results reported through the CDPH Blood Lead Registry may be used as a supplementary data source

Providers will be identified based on:

- National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1)
- If the rendering or ordering is not filled, then look for prescribing provider field that is an NPI for an individual (Type 1)
- If the rendering, ordering, or prescribing is not filled, then look for billing provider that is an NPI for an individual (Type 1)
- To qualify for payment, providers must be practicing within their practice scope and must have an individual (Type 1) NPI. For example, if a pharmacist (not the pharmacy) provides an immunization, then that pharmacist could receive payment.

Beneficiary inclusion criteria:

- Services for beneficiaries with Medicare Part B will be excluded
- Payments are based on Medi-Cal having the encounter data

Beneficiary exclusion criteria:

- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics, and Cost Based Reimbursement Clinics will be excluded from payment

An enhanced payment factor will be applied to the above services provided to beneficiaries with the following conditions:

- Substance Use Disorder (SUD) – CMS Core Set Measure Set: AOD Abuse and Dependence Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Serious Mental Illness (SMI) – CMS Core Set Measure Sets: Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set, and Major Depression Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Homeless ICD-10 Diagnosis code with the following values:
  - Z59.0 Homeless
  - Z59.1 Inadequate Housing

The SUD and SMI at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the measurement year. The diagnosis of homeless should be on the encounter data for the VBP eligible service.

Post utilization monitoring will be performed to ensure overuse of services is not occurring.

Technical Updates to the Specifications

Updated in May 7, 2020 Version:

- Removed from the Diabetes measure the reference to the Hemoglobin A1c (HA1C-AD) Testing measure, which was removed from the CMS Adult Core Set in the 2020 reporting year (data collection year 2019).
- Adjusted the Diabetes measure to indicate CPT 3045F is valid through September 30, 2019 and is replaced with CPT 3051F and CPT 3052F as of October 1, 2019.
- Removed from the Tobacco Use Screening measure codes CPT G0436 and CPT G0437, which were retired September 30, 2016.
- Added to the Screening for Unhealthy Alcohol Use measure codes CPT G0442 and CPT G0443.

Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a Health Network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted Provider.

B. A Provider shall submit a claim for Covered Services rendered on, or after, January 1, 2010 as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the contracted Provider agreement. If the contracted Provider agreement does not specify a time frame, the contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services - Emergency medical services *do not* require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of an inpatient admission from the ER on file for the room and board charges, CalOptima or a Health Network must pay the emergency triage fee and request Medical Records;

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3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima policies to be services the Member was entitled to have furnished, or paid for, by CalOptima or a Health Network; and

7. CalOptima or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts.

D. CalOptima or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider Agreement.

2. Non-Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

b. CalOptima or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

c. If CalOptima or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

d. CalOptima or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

i. Effective January 1, 2021, CalOptima or a Health Network ~~may~~shall apply positive MIPS payment adjustments ~~either at~~, within thirty (30) calendar days of receipt of a clean claim regardless of the ~~time the payment is made during the applicable MIPS~~

~~payment year or as a retroactive adjustment to paid claims.~~dates of service.

~~i. CalOptima or a Health Network are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.~~

E. If CalOptima or a Health Network denies payment of a Clean Claim, CalOptima or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the Member of his or her right to request an Appeal;

c. Describe the Appeals process, time frames, and other elements; and

d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program, but is covered by and payable under a Member's Medi-Cal coverage, CalOptima or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

~~H.~~I. Provider Appeal and Grievance

1. A Provider may Appeal a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

2. A Provider may file a Grievance in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

III. PROCEDURE

A. If CalOptima or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) working days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima or a Health Network receives an Invalid or Incomplete Claim, it shall notify the

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Provider no later than ten (10) working days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, CalOptima's or a Health Network notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) working days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

   a. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima or a Health Network shall send a second (2nd) letter to the contracted/Non-Contracted Provider requesting such information.

   b. If CalOptima or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a Provider Grievance, in accordance with Section II.I. of this Policy.

6. If CalOptima or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a Grievance in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima or a Health Network Reopening of Claims

1. CalOptima or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima or a Health Network, such as:

   a. Mathematical or computational mistakes;

   b. Transposed procedure or diagnostic codes;

   c. Inaccurate data entry;

   d. Misapplication of a fee schedule;

   e. Computer errors;

   f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

   g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

   a. Failing to bill for certain items or services;

   b. Untimely filing; or

   c. Redetermination requests.

3. CalOptima or a Health Network, a Provider, or any other party to the determination decision may request CalOptima or a Health Network reopen a claim as follows:

   a. The request may be made verbally or in writing.

   b. CalOptima or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

   c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima or a Health Network shall issue a revised electronic or paper remittance advice notice.

   d. If the reopening action results in an adverse revised claim determination or decision, CalOptima or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide Appeal rights.

4. When reviewing a request to reopen a claim, CalOptima or a Health Network can consider new and material evidence if it meets the following:

   a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

   b. Does not include evidence that was or reasonably could have been, available to the decision-maker at the time the decision was made; and

   c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

7. The decision of CalOptima or a Health Network to reopen a claim determination is not an initial claim determination and is therefore not subject to Appeal.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima or a Health Network shall ensure the following for written notifications:

a. Are delivered to the last known address when the determination or decision is reopened and revised;

b. State the rational and basis for the reopening and revision;

c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

d. Provide information on any appeal rights.

~~D.~~G. Record Maintenance

1. CalOptima or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NCMCP; OMB Approval 0938-0829 (Expires: 02/28/2023~~01/31/2020) H5433_UM17_3a (Rev 8/30/17))~~
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for

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Medicare Advantage

B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima PACE Program Agreement
D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy CMC.9005: Payment Appeal
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
I. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
J. CalOptima Policy MA.3103: Coordination of Benefits
K. CalOptima Policy MA.9003: Standard Appeal
L. CalOptima Policy MA.9004: Expedited Appeal
M. CalOptima Policy MA.9005: Payment Appeal
N. CalOptima Policy MA.9006: Provider Complaint Process
O. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
P. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
~~O.~~Q. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
~~P.~~R. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
S. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
~~Q.~~T. Patient Protection and Affordable Care Act, §6404
~~R.~~U. Title 31, United States Code (U.S.C.), §3902(a)
S. Title 42, Code of Federal Regulations (C.F.R.), ~~§§405.927, 405.980(a)(3),~~ 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review. PACE: A Participant's action taken with respect to the CalOptima PACE's non-coverage of, or nonpayment for, a service, including denials, reductions or termination of services. An Appeal may be filed verbally, either in-person or by telephone, or in writing. The Appeal process may take one (1) of two (2) forms: 1. Standard Appeal: A standard review process for response to and resolution of an Appeal as expeditiously as the Participant's health requires, but no later than thirty (30) days after the CalOptima PACE receives an Appeal. 2. Expedited Appeal: When a Participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute. CalOptima PACE shall respond to the Appeal as expeditiously as the Participant's health condition requires, but no later than seventy-two (72) hours after it receives the Appeal. The seventy-two (72)-hour timeframe may be extended by up to fourteen (14) calendar days for either of the following reasons: a. The Participant requests the extension; or ~~a.~~b. The PACE organization justifies to the State administering agency the need for additional information, and how the delay is in the interest of the Participant.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Term	Definition
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Emergency Care	PACE: Covered services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Emergency Services	~~Covered Services furnished~~OneCare/OneCare Connect: Those covered inpatient and outpatient services required that are: 1. Furnished by ~~Provider~~a physician qualified to furnish ~~those health~~emergency services ~~needed~~; and ~~1.~~2. Needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Grievance	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any ~~Complaint~~complaint or dispute, other than one ~~involving~~that constitutes an ~~Organization~~organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's~~, a Health Network's,~~ or ~~a~~ Provider's operations, activities, or behavior, regardless of ~~any request for remedial action~~whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). ~~Also~~ called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care. A Grievance may include, but is not limited to: 1. The quality of services a Participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility); 2. Waiting times on the telephone, in the waiting room or exam room; 3. Behavior of any of the care providers or PACE staff members; 4. Adequacy of center facilities; 5. Quality of the food provided; 6. Transportation services; and 7. A violation of a Participant's rights.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, ~~Health Network, Physician Medical Group,~~ or other person or institution who furnishes Covered Services.

Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a Health Network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted Provider.

B. A Provider shall submit a claim for Covered Services rendered on, or after, January 1, 2010 as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the contracted Provider agreement. If the contracted Provider agreement does not specify a time frame, the contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services - Emergency medical services *do not* require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of an inpatient admission from the ER on file for the room and board charges, CalOptima or a Health Network must pay the emergency triage fee and request Medical Records;

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3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima policies to be services the Member was entitled to have furnished, or paid for, by CalOptima or a Health Network; and

7. CalOptima or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts.

D. CalOptima or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider Agreement.

2. Non-Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

b. CalOptima or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

c. If CalOptima or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

d. CalOptima or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

i. Effective January 1, 2021, CalOptima or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a clean claim regardless of the dates of service.

E. If CalOptima or a Health Network denies payment of a Clean Claim, CalOptima or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

   a. The specific reasons for the payment denial;

   b. Inform the Member of his or her right to request an Appeal;

   c. Describe the Appeals process, time frames, and other elements; and

   d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program, but is covered by and payable under a Member's Medi-Cal coverage, CalOptima or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

I. Provider Appeal and Grievance

1. A Provider may Appeal a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

2. A Provider may file a Grievance in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

III. PROCEDURE

A. If CalOptima or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) working days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) working days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, CalOptima's or a Health Network notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) working days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

a. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima or a Health Network shall send a second (2nd) letter to the contracted/Non-Contracted Provider requesting such information.

b. If CalOptima or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a Provider Grievance, in accordance with Section II.I. of this Policy.

6. If CalOptima or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a Grievance in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima or a Health Network Reopening of Claims

1. CalOptima or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima or a Health Network, such as:

a. Mathematical or computational mistakes;

b. Transposed procedure or diagnostic codes;

c. Inaccurate data entry;

d. Misapplication of a fee schedule;

e. Computer errors;

f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

a. Failing to bill for certain items or services;

b. Untimely filing; or

c. Redetermination requests.

3. CalOptima or a Health Network, a Provider, or any other party to the determination decision may request CalOptima or a Health Network reopen a claim as follows:

a. The request may be made verbally or in writing.

b. CalOptima or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima or a Health Network shall issue a revised electronic or paper remittance advice notice.

d. If the reopening action results in an adverse revised claim determination or decision, CalOptima or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide Appeal rights.

4. When reviewing a request to reopen a claim, CalOptima or a Health Network can consider new and material evidence if it meets the following:

a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

b. Does not include evidence that was or reasonably could have been, available to the decision-maker at the time the decision was made; and

c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

7. The decision of CalOptima or a Health Network to reopen a claim determination is not an initial claim determination and is therefore not subject to Appeal.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima or a Health Network shall ensure the following for written notifications:

a. Are delivered to the last known address when the determination or decision is reopened and revised;

b. State the rational and basis for the reopening and revision;

c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

d. Provide information on any appeal rights.

G. Record Maintenance

1. CalOptima or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NCMCP; OMB Approval 0938-0829 (Expires: 02/28/2023)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima PACE Program Agreement

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D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy CMC.9005: Payment Appeal
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
I. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
J. CalOptima Policy MA.3103: Coordination of Benefits
K. CalOptima Policy MA.9003: Standard Appeal
L. CalOptima Policy MA.9004: Expedited Appeal
M. CalOptima Policy MA.9005: Payment Appeal
N. CalOptima Policy MA.9006: Provider Complaint Process
O. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
P. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
Q. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
R. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
S. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
T. Patient Protection and Affordable Care Act, §6404
U. Title 31, United States Code (U.S.C.), §3902(a)
S. Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare

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Action	Date	Policy	Policy Title	Program(s)
				OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review. PACE: A Participant's action taken with respect to the CalOptima PACE's non-coverage of, or nonpayment for, a service, including denials, reductions or termination of services. An Appeal may be filed verbally, either in-person or by telephone, or in writing. The Appeal process may take one (1) of two (2) forms: 1. Standard Appeal: A standard review process for response to and resolution of an Appeal as expeditiously as the Participant's health requires, but no later than thirty (30) days after the CalOptima PACE receives an Appeal. 2. Expedited Appeal: When a Participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute. CalOptima PACE shall respond to the Appeal as expeditiously as the Participant's health condition requires, but no later than seventy-two (72) hours after it receives the Appeal. The seventy-two (72)-hour timeframe may be extended by up to fourteen (14) calendar days for either of the following reasons: a. The Participant requests the extension; or b. The PACE organization justifies to the State administering agency the need for additional information, and how the delay is in the interest of the Participant.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Term	Definition
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Emergency Care	PACE: Covered services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Emergency Services	OneCare/OneCare Connect: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care. A Grievance may include, but is not limited to: 1. The quality of services a Participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility); 2. Waiting times on the telephone, in the waiting room or exam room; 3. Behavior of any of the care providers or PACE staff members; 4. Adequacy of center facilities; 5. Quality of the food provided; 6. Transportation services; and 7. A violation of a Participant's rights.

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Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution who furnishes Covered Services.

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Payment

Date:

Member number:

Claim number:

Name: **<Beneficiary's full name>**
<Beneficiary's street address>
<Beneficiary's city, state, zip>

Your request was *denied*

We've *denied* the *payment of medical services/items or Part B drug or Medicaid drug* listed below requested by you or your doctor [*provider]*:

Why did we deny your request?

We *denied* the *payment of medical services/items or Part B drug or Medicaid drug* listed above because

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare (HMO SNP) to review our decision by asking us for an appeal**.** [If the action taken involves Medicaid benefits insert the following: Plan level appeal's process must be exhausted prior to requesting a State Hearing.]

Plan Appeal: Ask OneCare for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with OneCare" for information on how to ask for a plan level appeal.

> ***How to keep your services while we review your case:*** *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your appeal, you may have to pay for these services.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: **1-877-412-2734** to learn how to name your representative. TTY users call <**1-800-735-2929**>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Important Information About Your Appeal Rights

There are 2 kinds of appeals with OneCare

Standard Appeal – We'll give you a written decision on a standard appeal within ***30 days*** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a medical service/item or Part B drug you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a *medical service/item or Part B drug* you've already received.

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with OneCare

Step 1: You, your representative, or your doctor [*provider*] must ask us for an appeal. Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the *medical service/item or Part B drug or Medicaid drug*. Call your doctor if you need this information.

If you're asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.
We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal. You can also call us .

For a Standard Appeal:

Mailing Address: OneCare
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868
Phone: 1-877-412-2734 TTY Users Call: <1-800-735-2929>
Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: 1-877-412-2734 TTY Users Call: <1-800-735-2929>
Fax: 1-714-246-8562

What happens next?

If you ask for an appeal and we continue to deny your request for *payment of* a *medical service/item or Part B drug or Medicaid drug*, we'll automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

How to ask for a Medicaid State Fair Hearing

If OneCare denies your appeal request, you can take the steps listed below to request a State Fair Hearing.

Step 1: *You or your representative must ask for a State Fair Hearing (in writing) within 120 days of the date of the notice that denies your appeal request. You have up to <180> days if you have a good reason for your request being late.*

Your {written} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: *Send your request to:*
California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Phone: 1-800-952-5253 Fax: 1-916-651-5210 or 1-916-651-2789

[A copy of this notice has been sent to:]

Get help & more information

- OneCare Customer Service: Toll Free: 1-877-412-2734, TTY users call: <1-800-735-2929> 24 hours, 7 days a week or www.caloptima.org/onecare.
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.
- Medi-Cal Managed Care Ombudsman Office: 1-888-452-8609
- Office on Aging, OC Community Services: 1-800-510-2020

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-412-2734** (TTY: <**1-800-735-2929**>).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-412-2734** (TTY: <**1-800-735-2929**>).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-412-2734** (TTY: <**1-800-735-2929**>).

{Enclosures: Notice of Non Discrimination: H5433_20MM012_C}

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." You can also see Chapter 9 of the Member Handbook for information about how to make an appeal.

Notice of Denial of Payment

Date:

Member number:
Claim number:

Name:

Your request was denied

We've denied the payment of medical services/items listed below requested by you or your doctor [*provider*]:

[service] [service dates]

Why did we deny your request?

We denied the payment of medical services/items listed above because:

[Remarks]

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) to review our decision by asking us for a Level 1 Appeal (sometimes called an "internal appeal" or "plan appeal").

Level 1 Appeal with OneCare Connect: Ask OneCare Connect for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for a Level 1 Appeal with OneCare Connect" for information on how to ask for a plan level appeal.

How to keep your services while we review your case: *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-855-705-8823 to learn how to name your representative. TDD/TTY users call 1-800-735-2929. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

There are 2 kinds of Level 1 appeals with OneCare Connect

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**.

Fast (Expedited) Appeal *– We'll give you a decision on a fast appeal as expeditiously as your condition requires, and always within* ***72 hours*** *after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a decision on a standard appeal.*

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. *If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.*

How to ask for a Level 1 Appeal with OneCare Connect

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal: Address: OneCare Connect
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

Phone: 1-855-705-8823 TTY Users Call: 1-800-735-2929
Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

For a Fast (Expedited) Appeal: Phone: 1-855-705-8823 TTY Users Call: 1-800-735-2929
Fax: 1-714-246-8562}

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for {*payment of*} a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree.

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of this notice. Fill out the "Form to File a State Hearing" that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TDD: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

A copy of this notice has been sent to: [*insert name*]

Get help & more information

- Call **OneCare Connect** at 1-855-705-8823, 24 hours, 7 days a week. TDD/TTY users call 1-800-735-2929. You can also visit our website at www.caloptima.org/onecareconnect.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-888-HMO-9050.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- If this notice is about your In-Home Supportive Services (IHSS) benefits, call your **local county social services office** for help. The phone number is 1-714-825-3000 and 1-800-281-9799.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also see **Chapter 9 of the Member Handbook** for information about how to make an appeal.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. You can get this information for free in other languages. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-855-705-8823 (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-855-705-8823 (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝
1-800-735-2929):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم
(الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**) **1-855-705-8823**

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau
1-855-705-8823 (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ **1-855-705-8823 (TTY: 1-800-735-2929)**.

CalOptima PACE
13300 Garden Grove Blvd
Garden Grove, CA 92843
(714) 468-1100
TDD/TTY: (714) 468-1063

{Date}

{Participant's Name or Representative}
{C/o Participant's Name}
{Address}

RE: Notice of Action (NOA) for Service or Payment Request

Dear Mr/s {Name}:

Your request of [insert date] for [insert brief description of requested service or payment for service]

Has been: __**Denied** __**Deferred** __**Modified** for the reason(s) indicated below:

- ❑ Is not medically necessary
- ❑ Requested services will not improve or contribute to sustaining your health
- ❑ An alternative service is provided to meet your care needs
- ❑ Did not meet authorization criteria
- ❑ Is not a benefit of the PACE Program
- ❑ Requires additional information or consult
- ❑ Requested service has potentially negative health and safety issues
- ❑ Other (please describe):_____

This decision was based on the following criteria or clinical guidelines:
Claim ID can be included here with your language about the decision.
_____
_____

If you do not agree with the action above, you have the right to appeal the decision. Please see the attached *"Information for Participants about the Appeals Process"* for your right to request further action. You may call your Social Worker or our Quality Assurance Department at (714) 468-1100 who will explain these processes to you. For the hearing impaired (TTY/TDD), please call (714) 468-1063.

Sincerely,

[First Initial and last name of Examiner
Claims Administration

INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

All of us at **CalOptima PACE** share responsibility for your care and your satisfaction with the services you receive. Our appeals process is designed to enable you and/or your representative the opportunity to respond to a decision made by the Interdisciplinary Team regarding your request for a service or payment of a service. At any time you wish to file an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because an appeal has been filed. **CalOptima PACE** will continue to provide you with all the required services during the appeals process. The confidentiality of your appeal will be maintained at all times throughout and after the appeals process and information pertaining to your appeal will only be released to authorized individuals.

When **CalOptima PACE** decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing— is called an "**appeal**." You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process at enrollment (see your Member Enrollment Agreement Terms and Conditions) and annually after that. You will also receive this information and necessary appeals forms whenever **CalOptima PACE** denies, defers or modifies a request for a service or request for payment.

Definitions:
An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service, including denials, reductions or termination of services.

A **representative** is the person who is acting on your behalf or assisting you, and may include, but is not limited to, a family member, a friend, a PACE employee or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If you

request and expedited appeal, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

*Note: For **CalOptima PACE** participants enrolled in Medi-Cal – **CalOptima PACE** will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.*

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and **CalOptima PACE** denies, defers or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.
2. You can make your appeal either verbally(in person or by telephone) or in writing; ask any PACE Program staff of the center you attend to help you start the process. CalOptima PACE will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review. To submit relevant facts and/or evidence in writing, please send to the address listed below. Otherwise you or your representative may submit this information in person. If more information is needed, you will be contacted by **the Quality Assurance Department** who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our **Quality Assurance Department** at **714-468-1100 or our toll-free number at (855) 785-2584** to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call **(714) 468-1063**.
4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   Quality Assurance Department
   CalOptima PACE
   13300 Garden Grove Blvd
   Garden Grove, CA 92843

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For and expedited appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.

6. The reconsideration of **CalOptima PACE** decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon **CalOptima PACE** completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, **CalOptima PACE** will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on your Appeal:

If we decide fully in your favor on a **standard appeal** for a request for ***service***, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide in your favor** on a request for ***payment***, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights,** below). We also are required to notify you as soon as we make a decision and also to notify the federal Center for Medicare and Medicaid Services and the Department of Health Care Services. We will inform you in writing of your **external** appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which external program to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

If we decide fully in your favor on an **expedited appeal** we are required to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights**). We are required to notify you as soon as we make a decision and also to notify the Center for Medicare and Medicaid Services and the Department of Health Care Services. We let you know in writing of your **external appeal** rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

The **Medicare program** contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if **CalOptima PACE** wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in **Medicare Medi-Cal program or both,** we will help you choose which external appeal process you should follow. We also will send your appeal on to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal options are described below.

Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: (800)-952-5253
Facsimile: (916) 651-5210 or (916) 651-2789
TDD: (800)-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the *Notice of Action (NOA) for Service or Payment Request* from **CalOptima PACE**.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend, or an attorney. You may also be able to get free legal help. Attached is a list of Legal Services offices in **Orange County**, if you would like legal services assistance.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, **CalOptima PACE** will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is **not** in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeals, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medicare only,** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal file to the current contracted Medicare appeals entity to impartially review the appeal. The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor. The current Medicare appeals entity is:

Maximus Federal Services
Medicare Managed Care & PACE
Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14524-1302
Telephone: (585) 348-3300
Facsimile: (585) 425-5292

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: April 20, 2020

ALL PLAN LETTER 20-010
SUPERSEDES POLICY LETTER 08-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: COST AVOIDANCE AND POST-PAYMENT RECOVERY FOR OTHER HEALTH COVERAGE

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification and guidance to Medi-Cal managed care health plans (MCPs) with respect to the requirements for cost avoidance and post-payment recovery when an MCP member has other health coverage (OHC). These requirements also include instructions on the use of the Department of Health Care Services' (DHCS) Medi-Cal eligibility record to process OHC claims and guidelines on reporting to DHCS if the MCP becomes aware of OHC that is not listed on the eligibility record.

BACKGROUND:
State law requires Medi-Cal to be the payer of last resort for services in which there is a responsible third party.[1] Medi-Cal members with OHC must utilize their OHC for covered services prior to accessing their Medi-Cal benefits.[2] Cost avoidance is the practice of requiring providers to bill liable third parties prior to seeking payment from the Medi-Cal program.

Pursuant to federal law, states must take all reasonable measures to determine the legal liability of third parties and seek reimbursement for covered services for which the third party is liable.[3] This requirement is referred to as post-payment recovery and

[1] Welfare and Institutions Code (WIC) section 14124.90 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14124.90
[2] Title 22 of the California Code of Regulations (CCR), section 50763(a)(3). CCRs are searchable at: https://govt.westlaw.com/calregs/Document/IB1B147B0D4B811DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
[3] Social Security Act section 1902(a)(25) is available at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

extends to MCPs that administer health care on behalf of DHCS. MCPs that have accepted a claim from a provider for which there was OHC present on the member's Medi-Cal eligibility record at the time of service must engage in post-payment recovery for the reasonable value of the services from the liable third party. Additional information detailing private health care coverage requirements are further defined in state law[4] and the MCP contracts.[5]

POLICY:

1. Using the Medi-Cal Eligibility Record for Processing OHC Claims

    - MCPs should rely on the Medi-Cal eligibility record for cost avoidance and post-payment recovery purposes.
    - MCPs that become aware of OHC from sources other than the Medi-Cal eligibility record may use this OHC information, but must report the OHC to DHCS by submitting an OHC Removal or Addition form[6] or through batch updates[7].

2. OHC Reporting Requirements and Delivery Options

    - MCPs must report new OHC information not found on the Medi-Cal eligibility record or OHC information that is different from what is found on the Medi-Cal eligibility record to DHCS within 10 calendar days of discovery. This requirement ensures timely receipt of all new or updated OHC information so that the Third Party Liability and Recovery Division (TPLRD) can verify the information and update the member's Medi-Cal eligibility record, if valid. MCPs must report this OHC information to DHCS by either:

        - Completing and submitting an OHC Removal or Addition form; or
        - Reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. MCPs

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[4] WIC section 10022 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=10022.&lawCode=WIC

[5] The MCP boilerplate contract is available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

[6] The OHC Removal and Addition forms are available at: https://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx

[7] Batch processing (multiple additions/removals at a time) is done via weekly submission of an HI-36 Excel spreadsheet. Contact your MCP contract manager for the HI-36 template and instructions on how to complete it.

can contact their Managed Care Operations Division (MCOD) Contract Manager for more information regarding this process.

- Beginning January 1, 2021, MCPs must include OHC information in their notification to the provider when a claim is denied due to the presence of OHC. OHC information includes, but is not limited to, the name of the OHC provider, the policy number, and contact or billing information. OHC information known to DHCS is provided to all MCPs on a monthly basis. Prior to January 1, 2021, MCPs may direct providers to access the necessary member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295, or the Medi-Cal Online Eligibility Portal.[8] Information pertaining to OHC carriers can be found in the Health and Human Services Open Data Portal.[9]

3. Cost Avoidance

- Prior to delivering services to members, MCPs must ensure providers review the Medi-Cal eligibility record for the presence of OHC. If the member has active OHC, MCPs must ensure providers compare the OHC code (Appendix A) to the requested service. If the requested service is covered by the OHC, MCPs must ensure providers instruct the member to seek the service from the OHC carrier.
- Regardless of the presence of OHC, MCPs must ensure providers do not refuse a covered Medi-Cal service to a Medi-Cal member.[10]
- Effective February 9, 2018, in accordance with federal law, prenatal care is subject to cost avoidance.[11] In cases where prenatal service billing is bundled with claims for other services, MCPs must ensure providers cost-avoid the entire claim.
- MCPs must not process claims for a member whose Medi-Cal eligibility record indicates OHC, other than a code of A or N, unless the provider presents proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly. For more information regarding direct bill services, please refer to the list of direct bill Current Procedural

[8] The Medi-Cal Online Eligibility Portal is available at: https://www.medi-cal.ca.gov/Eligibility/Login.asp
[9] The Health and Human Services Open Data Portal is available at: https://data.chhs.ca.gov/dataset/aevs-carrier-codes-for-other-health-coverage
[10] Title 42 U.S. Code section 1396a(a)(25)(D) is available at: https://www.law.cornell.edu/uscode/text/42/1396a
[11] Section 53102 of the Bipartisan Budget Act of 2018 is available at: https://www.congress.gov/bill/115th-congress/house-bill/1892/text

Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes.[12]
- Acceptable forms of proof that all sources of payment have been exhausted include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation that the provider has billed the OHC and received no response for 90 days.

4. Post-Payment Recovery

- MCPs must engage in post-payment recovery if OHC is discovered retroactively or the member had an OHC indicator code of A on their Medi-Cal eligibility record at the time of service.
- For the purpose of post-payment recovery, the reasonable value of the services is the average payment the MCP pays for similar services in the particular service area, but in no event less than the Medi-Cal fee-for-service payment rate for the services rendered.
- MCPs that initiate and complete post-payment recovery within 12 months from the date of payment of a service are entitled to retain all monies recovered.
- DHCS' TPLRD will conduct post-payment recoveries and/or leverage its recovery contractor to initiate post-payment recovery beginning the 13th month following the date of payment of a service. TPLRD's recovery contractor assists with the identification and recovery of paid Medi-Cal claims for which there is liable third party. Monies recovered by TPLRD or its recovery contractor starting the 13th month after the date of payment of a service will be retained by DHCS.
- Beginning June 1, 2020, MCPs are required to submit detailed information regarding their recoveries to DHCS on a monthly report utilizing DHCS' Secure File Transfer Protocol no later than the 15th of each month. (See Appendix B for the specifics regarding the file format, required data elements, and other submission requirements).
- On a monthly basis, MCPs must report and return all recovered monies that are 13 months or older from the date of payment of a service to DHCS utilizing the monthly report (Appendix B).
- MCPs must remit warrants, payable to DHCS, for all recovered monies that are 13 months or older from the date of payment of a service to the following address:

Bank of America
P.O. Box 742635
Los Angeles, CA 90074-2635

[12] The full list of direct bill CPT and HCPCS codes is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/othhlthcpt_m00o00a02a05.doc

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

DATE January 31, 2007

MMCD All Plan Letter 07002

TO: County Organized Health Systems
Geographic Managed Care Plans
Two-Plan Model Plans

SUBJECT: *Conlan v. Bontá; Conlan v. Shewry*: Court Ordered Medi-Cal Beneficiary Reimbursement Process

Purpose

This letter provides specific instruction to County Organized Health Systems (COHS), Geographic Managed Care (GMC), and Two-Plan Model contractors and clarifies their obligations pursuant to the order(s) issued by the Superior Court, County of San Francisco in the above-referenced matters.

The California Department of Health Services (CDHS) has been ordered by the Superior Court to implement a process enabling Medi-Cal beneficiaries to obtain reimbursement of paid out-of-pocket expenses for Medi-Cal covered services received during specific periods of a beneficiary's Medi-Cal eligibility. These periods include 1) the retroactive eligibility period (up to 3 months prior to the month of application to the Medi-Cal Program); 2) the evaluation period (from the time of application to the Medi-Cal Program until eligibility is established), and 3) the post-approval period (the time period after eligibility is established).

Background

Please see the attached enclosure A, CDHS Revised Plan for Beneficiary Reimbursement, regarding the *Conlan v. Bontá; Conlan v. Shewry* court ordered Medi-Cal beneficiary reimbursement process.

Medi-Cal Managed Care Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Telephone (916) 449-5000 Fax (916) 650-0240
Internet Address: www.dhs.ca.gov

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Implementation

CDHS is proceeding with timely implementation of the *Conlan* court decisions and orders pursuant to the court-approved Plan.[1]

Medi-Cal providers will be sent additional and periodic bulletins to notify them of this reimbursement process and to remind them of their responsibilities to promptly reimburse beneficiaries who may have paid out-of-pocket expenses for Medi-Cal covered services. Provider bulletins will also remind providers that, for Medi-Cal managed care beneficiaries, providers must verify eligibility and seek prior authorization from the Medi-Cal managed care plan before rendering services that are non-emergency. Providers risk non-payment of claims for services if they are not a member of the provider network of the managed care plan in which the beneficiary is enrolled.

CDHS has begun mailing the Beneficiary Notice to the address of record of all current beneficiaries, as well as those individuals who were eligible at any time since June 27, 1997. The Beneficiary Notice will be sent to an estimated 11 million households. A copy of the notice is attached to the Revised Plan. The Beneficiary Notice will be printed in English and Spanish and will be accompanied by a separate enclosure entitled "REQUEST FOR NOTICE IN OTHER LANGUAGES" printed in nine additional languages spoken by the largest number of non-English speaking beneficiaries in California. Telephone operators dedicated to the reimbursement process will be available to assist beneficiaries in translating their notice from English/Spanish to the nine additional languages. It will take several weeks to complete the mailing of all Beneficiary Notices to the estimated 11 million Medi-Cal households.

The Beneficiary Notice will instruct beneficiaries to contact CDHS' Beneficiary Service Center located at Electronic Data Systems (EDS), which will be dedicated specifically to the beneficiary reimbursement process. At the time of contact, the beneficiary will be directed to the appropriate staff (medical, dental, etc.) and will receive information on what is required in order to properly submit a complete claim and for the involved department or program to approve claims for reimbursement. CDHS has developed a standardized claim form with directions on how to complete the form that can be mailed to the beneficiary at the time of initial contact and upon request to:

[1] Attached as Exhibits A and B: CDHS Revised Plan for Beneficiary Reimbursement; November 17, 2006, Superior Court order, approving same.

Beneficiary Service Center
P.O. Box 138008, Sacramento, CA 95813-8008
(916) 403-2007 or for TDD service (916) 635-6491

As a first step, CDHS will mail a claim packet to the beneficiary and the beneficiary will be directed to mail the completed claim packet to the Beneficiary Service Center, which includes:

- The Beneficiary Reimbursement Claim Form with beneficiary information;
- A completed PAYEE DATA RECORD Form (STD 204);
- A summary itemizing the covered expense(s) for which the beneficiary paid including proof of payment that shows receipt and payment of a service(s). In some cases a declaration might supplement other documentary evidence;
- A copy of his/her Medi-Cal Beneficiary Identification Card (BIC);
- The dates of service(s);
- The provider'(s) name(s) with address(es) and phone number(s) if known; and
- For those Medi-Cal services that would have required Medi-Cal authorization, documentation from the medical or dental provider that shows medical necessity for the service.

Impact to Managed Care Plans

COHS plans are capitated for Medi-Cal covered services, with the exception of those services carved-out of the contract, for the three reimbursement periods covered by the court orders. GMC and Two-Plan Model plans are capitated for Medi-Cal covered services, with the exception of those services carved-out of the contract, for the post-approval period. Therefore, a process to comply with the court-ordered reimbursement to Medi-Cal beneficiaries of paid out-of-pocket expenses for covered services will be the responsibility of the managed care plans. This applies to all beneficiaries who are/were enrolled in the plans during any of the three time periods identified that are applicable to the plan.

Claims Process

Completed claims for reimbursement will need to be adjudicated within 120 days of receipt of the beneficiary's completed claim for Medi-Cal covered expenses incurred and paid during the three time periods identified. In addition, when it is appropriate and Medi-Cal providers cooperate or funds are available from a Medi-Cal provider for recoupment, beneficiary reimbursement will be for the beneficiary's full payment of out-

of-pocket expenses. This includes amounts above the Medi-Cal rate for Medi-Cal covered services. However, if recoupment is not appropriate, then the plans will reimburse the beneficiary directly for the valid claim up to the amount paid but not to exceed the Fee-For-Service rate established under the Medi-Cal program.

Upon receipt of the beneficiary's claim by the Beneficiary Service Center, EDS will review the claim to determine if the claim is complete and meets certain criteria in order to qualify for reimbursement. Please see the attached Claim Process flow chart which outlines the claim process and lists the criteria for processing beneficiary claims. EDS will review the claim for the following criteria:

- The beneficiary was eligible for Medi-Cal at the time the service(s) was(were) provided;
  The claimed service(s) was(were) provided on or after June 27, 1997;
  The service(s) provided was(were) a Medi-Cal covered service – i.e. a Medi-Cal benefit at the time the service(s) was(were) rendered;
- The beneficiary was eligible to receive the service(s) at the time the service(s) was(were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits;
- The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.) with an itemized list of services covered by the payment, and to whom the payment was made;
  The beneficiary has submitted a completed STD 204 form;
  Claims for the evaluation period for dates of service on or after February 2, 2006, or for the post approval period were rendered by a Medi-Cal provider at the time the service(s) was provided, and
- The claim was submitted timely. Submission timelines for a timely claim are:

    1. For services received June 27, 1997 through November 16, 2006, claims must be submitted by November 16, 2007, or within 90 days after issuance of the Medi-Cal card, whichever is longer.
    2. For services received on or after November 16, 2006, claims must be submitted within one year of receipt of services or within 90 days after issuance of the Medi-Cal card, whichever is longer.

Within 15 days of receipt of the beneficiary claim, EDS will redistribute the completed claim to the managed care plan for adjudication when the claim, depending on the claim and service type, involves services covered by the managed care plan. The claim will

be sent with a Beneficiary Reimbursement Claim Referral. A copy of the referral is attached. The adjudication timeline of 120 days will begin anew from the date the managed care plan receives the completed claim from EDS. Managed Care plans will be required to send the referral form back to EDS upon adjudication of the claim.

State Hearings – New Procedures

If all or part of the beneficiary's claim is denied, managed care plans must send the beneficiary a Notice of Action (NOA) explaining what was denied and why. The NOA will provide information on how the beneficiary may file for a State Hearing. The beneficiary has 90 days from the date of the NOA to request a State Hearing.

The current State Hearing process for beneficiaries resolves disputes involving any adverse actions related to Medi-Cal eligibility or benefits. The current process is not a remedy for Medi-Cal providers to resolve other Medi-Cal payment or funding issues. However, for beneficiary reimbursement claims, the option to file a State Hearing is extended to the Medi-Cal providers, who will be allowed to provide evidence that the proposed reimbursement and recoupment is not correct. Please see the attached Revised Plan for Beneficiary Reimbursement for the detailed description of the State Hearing process outlined in the heading entitled: "G. State Hearings – New Procedures."

Should you have any questions or require additional information regarding the content of this letter, please contact your Contract Manager.

Sincerely,

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Attachments

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California Department of Health Services' Revised Plan for Beneficiary Reimbursement *Conlan v. Bontá; Conlan v. Shewry*

A. Procedural History/Background

Petitioners initiated the lawsuit entitled *Conlan v. Bontá* in June 1997. Following a ruling where the trial court denied the petition for writ in its entirety, the Court of Appeal reversed the trial court's decision in *Conlan v. Bontá* (2002) 102 Cal.App.4th 745 (*Conlan I*). In *Conlan I*, the court held that under 42 U.S.C. section 1396a(a)(10)(B) (the "comparability provision") the California Department of Health Services (Department) was required to implement a process by which Medi-Cal beneficiaries may obtain prompt reimbursement for covered services for which they paid during the three months prior to applying for Medi-Cal coverage (the "retroactivity period").

Following the issuance of *Conlan I*, the Department submitted a proposed Compliance Plan (Plan) to the trial court. Petitioners objected to several of the Plan's key provisions. The trial court found for the petitioners on all issues and concluded that the provisions were invalid. The trial court refused to approve the Department's Plan without modification to the Plan's disputed provisions. The Department appealed from that order.

On August 15, 2005, the California Court of Appeal issued its decision in the case of *Conlan v. Shewry* (2005) 131 Cal.App.4th 1354 (*Conlan II*).

In *Conlan II*, the Court of Appeal addressed five key issues relevant to the Plan's implementation. The court dismissed the Department's position that the trial court's ruling was (among other things) in conflict with California law (see Welfare and Institutions Code section 14019.3), in conflict with specific instructions from the Centers for Medicare and Medicaid Services (CMS) regarding this case (November 17, 2003 letter from CMS), and an invitation to fraud and abuse of the Medi-Cal Program. Ultimately, the court held that the Department is required to:

(1) Send notice of the new monetary reimbursement process available to all current and former Medi-Cal beneficiaries who may have claims arising on or after June 27, 1997;

(2) Provide monetary reimbursement to any individual who has a valid claim for reimbursement arising on or after June 27, 1997;

(3) Provide reimbursement for valid claims arising from the date an application for Medi-Cal eligibility is submitted to the date that the application is granted (the "evaluation period");

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(4) Provide reimbursement for services rendered by non-Medi-Cal providers if the services were provided during the retroactivity period (the Department is not required to provide reimbursement for services rendered by non-Medi-Cal providers during the evaluation period); and

(5) For valid claims, reimburse the beneficiary the amount paid, not to exceed the rate established for that service under the Medi-Cal program.

Following the issuance of *Conlan II*, the Department again submitted a proposed Plan to the trial court. In response, petitioners objected to six of the Plan's key provisions.

On February 8, 2006, the trial court found for the petitioners on four of the six issues presented, including three issues to which the Department had previously stipulated to resolve as demanded by the petitioners. Most notably, the court found that Welfare and Institutions Code, section 14019.3(g), required the Department to implement an enforcement action in order to "aggressively encourage" providers to cooperate in reimbursing beneficiary claims for reimbursement.[1] To comply with this order, the Department proposes in this Revised Plan for Beneficiary Reimbursement (Revised Plan) for court approval of the enforcement action entitled "Recoupment" by which the Department will permanently divert expected payments from a Medi-Cal provider in order to reimburse the beneficiary's valid claim.

The trial court also found that the issue regarding reimbursement of post approval expenses was not ripe for decision. The court stated it would decide "whether and the extent to which post-eligible reimbursement shall be made to beneficiaries" at a future hearing following a noticed motion and full briefing.

At the further hearing held on May 4, 2006, the trial court found for the petitioners regarding reimbursement of post approval expenses. The court directed the Department to expand the scope of post approval reimbursement, specifically invalidating a portion of Welfare and Institutions Code, section 14019.3(a)(1) that limits post approval claims for reimbursement to excess co-payments. The court issued its written order on May 18, 2006.

B. Policies/Steps Implemented

[1] "The Court hereby directs the Department to develop a more proactive provider reimbursement scheme, one that aggressively encourages voluntary provider compliance. That scheme shall set forth the specific steps the Department will take to 'ensure' voluntary compliance (W&I Code section 14019.3(h)), as well as the enforcement action the Department will follow if its voluntary compliance efforts are not successful (W&I Code section 14019.3(g)). To put the Court's expectations more directly, albeit in a somewhat colloquial manner: 'Let's see some teeth here.'" (Trial court's order, February 8, 2006: page 4, lines 11-18.)

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As a result of the trial court's February 8 and May 18, 2006 orders, the Department initiated and/or completed the following steps:

Identified and developed a process for taking action to recoup beneficiary out-of-pocket payments made to Medi-Cal providers after which a Medi-Cal provider can submit a claim to Medi-Cal for reimbursement at the Medi-Cal rate for the Medi-Cal covered service provided. (Addresses the February 8, 2006 trial court order, Issue 1

Established a new State Hearing procedure expanding the current Department of Social Services' (DSS) State Hearing process to specifically address Medi-Cal provider appeals from proposed recoupment actions. This new procedure will include Medi-Cal providers in the State Hearing when they object to a proposed recoupment by the Department on behalf of the claiming beneficiary. To accomplish this expanded procedure, the Department:

- Met with DSS weekly to identify changes to the current process,
- Developed procedures specifying steps to be taken in processing State Hearing requests,
- Reviewed current legal authority for the State Hearing process,
- Identified necessary changes to legal authority in order to implement the new State Hearing procedure. (Addresses the February 8, 2006 trial court order, Issue 1.)

Developed a notice of action (NOA) that includes a State Hearing request form for beneficiary and Medi-Cal provider requests for a State Hearing involving reimbursement process requests. (Addresses the February 8, 2006 trial court order, Issue 1.)

Expanded the Plan and Beneficiary Notice to reflect inclusion of beneficiary reimbursement for excess share of cost payments and other Medi-Cal covered services for which the beneficiary paid after Medi-Cal eligibility was determined. (Addresses the February 8, 2006 trial court order, Issue 2; and the May 18, 2006 trial court order.)

Directed DSS to send a copy of all beneficiary reimbursement State Hearing decisions to the Department. The Department will process with the decision without further action from the beneficiary. (Addresses the February 8, 2006 trial court order, Issue 3.)

Revised the Plan to reflect the 90-day timeframe for filing claims after the beneficiary is issued their Medi-Cal card. (Addresses the February 8, 2006 trial court order, Issue 4.)

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Developed an enclosure in nine additional languages to include with the Beneficiary Notice. The enclosure advises beneficiaries to call the Beneficiary Service Center telephone number if they need the notice translated in their language. (Addresses the February 8, 2006 trial court order, Issue 5.)

Developed a Beneficiary Reimbursement Claim Form for submission by a beneficiary requesting reimbursement of out-of-pocket payments for Medi-Cal covered services.

Updated the Medi-Cal beneficiary information booklet and application forms reminding Medi-Cal applicants that they need to utilize Medi-Cal providers when they receive Medi-Cal covered services in order to be reimbursed by Medi-Cal.

Coordinated meetings with other State departments and agencies regarding implementation and expectations regarding the new reimbursement process.

Revised reimbursement process notification template letters to be used during the claims adjudication process.

C. Implementation

This Plan will be implemented to the extent that Federal Financial Participation funding is available.

The Department will adjudicate completed claims for reimbursement (usually within approximately 120 days of receipt of the beneficiary's completed claim) of Medi-Cal covered services expenses incurred and paid during the retroactive period (up to 3 months prior to the time of application), during the evaluation period (from the time of application to the Medi-Cal program until the issuance of the beneficiary's Medi-Cal card), and in the post-approval period (the time period after issuance of the beneficiary's Medi-Cal card). In addition, when it is appropriate and Medi-Cal providers cooperate or funds are available from a Medi-Cal provider for recoupment,[2] beneficiary reimbursement will be for the beneficiary's full payment of out-of-pocket expenses. This includes amounts above the Medi-Cal rate for Medi-Cal covered services.

With court approval of this Revised Plan, the method of reimbursement will include: "cooperative" payments by providers; "recoupment" actions against uncooperative

[2] Whether the recoupment process is appropriate will be determined by the department or program reviewing the claim for final adjudication and/or payment. If recoupment is not appropriate, then the involved department will reimburse the beneficiary directly for the valid claim at the amount paid, not to exceed the rate established for the service under the Medi-Cal program.

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Medi-Cal providers, as more fully set forth below; and, when necessary, direct reimbursement to the beneficiary from the Department up to the current Medi-Cal rate for the applicable Medi-Cal covered services.

D. Beneficiary Notice

Upon court approval of this Revised Plan and the Beneficiary Notice, the Department will begin the process of mailing the Beneficiary Notice to the address of record of all current beneficiaries, as well as those individuals who were eligible at any time since June 27, 1997. This Beneficiary Notice is attached to the Revised Plan. The Beneficiary Notice will be sent to an estimated 11 million households. The cost of mailing this notice exceeds $3,000,000.

The Beneficiary Notice will be printed in English and Spanish and will be accompanied by a separate enclosure in which the following is printed in nine additional languages spoken by the largest number of non-English speaking beneficiaries in California:

> "REQUEST FOR NOTICE IN OTHER LANGUAGES
>
> If you were eligible for Medi-Cal anytime since June 27, 1997, or are eligible now, Medi-Cal may reimburse you for medical or dental bills that you paid. This notice tells you how to get more information. If you need this information in (insert appropriate language), please call (916) 403-2007." (Addresses February 8, 2006 court order, Issue 5.)

Telephone operators dedicated to the reimbursement process will be available to assist beneficiaries in translating their notice from English/Spanish to the nine (9) additional languages.

The printing and mailing of the Beneficiary Notices is dependent upon and will follow court approval. This Beneficiary Notice mailing activity will begin upon receipt of the court's approval of the Revised Plan. It will take several weeks to complete the mailing of all Beneficiary Notices to an estimated 11 million Medi-Cal households.

Medi-Cal providers will be sent additional and periodic bulletins to notify them of this reimbursement process and to remind them of their responsibilities to promptly reimburse beneficiaries who may have paid out-of-pocket expenses for Medi-Cal covered services.

E. Process of Beneficiary Claim Review/Adjudication

The process of beneficiary claims review/adjudication includes the following elements and approximate timelines (calendar days):

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Prior to receipt of a complete beneficiary claim:

The beneficiary may contact the Department's Beneficiary Service Center (which will be dedicated specifically to the new beneficiary reimbursement process and staffed by 40 telephone operators and correspondence staff at implementation) by mail or by phone. At the time of contact, the beneficiary will be directed to the appropriate staff (medical, dental, etc.) and will receive information on what is required in order to properly submit a complete claim and for the involved department or program to approve claims for reimbursement. The Department has developed a standardized claim form with directions on how to complete the form that can be mailed to the beneficiary at the time of initial contact and upon request. As a first step, the Department will mail a claim packet to the beneficiary and the beneficiary will be directed to mail the completed claim packet which includes: the Beneficiary Reimbursement Claim Form with beneficiary information, a completed STD 204 form; a summary itemizing the covered expense(s) for which the beneficiary paid including proof of payment that shows receipt and payment of a service(s) (in some cases a declaration might supplement other documentary evidence); a copy of his/her Medi-Cal Beneficiary Identification Card (BIC); the dates of service(s); the provider'(s) name(s) with address(es) and phone number(s) if known; and for those Medi-Cal services that would have required Medi-Cal authorization, documentation from the medical or dental provider that shows medical necessity for the service.

For CDHS fee for service claims:

Day 1 – The beneficiary's completed claim is received by the Department;

Day 2 to 15 –

Redistribute the completed claims to other involved departments or programs for adjudication when the claim, depending upon claim/service type, involves services administered outside of the Medi-Cal fee-for-service program (the adjudication timeline will begin anew from the date the other department or program receives the completed claim, as listed in "Day 1" above)[3]; or

2. The Department will acknowledge receipt of the beneficiary's claim in writing.

By Day 15 from receipt of the beneficiary's completed claim the Department will either:

Notify the beneficiary in writing that the claim has been denied. The written notice will include an explanation of the reason(s) for denial based upon the information submitted and a NOA explaining their hearing right and procedure to request a State Hearing,

[3] Redistribution to other involved departments or programs may delay the initial adjudication of a claim and subsequent notifications.

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2. Notify the beneficiary that additional information is required in order to process the claim, or

   Contact the healthcare provider by letter and request full reimbursement for the beneficiary. If the healthcare provider is a Medi-Cal provider and it is determined that the funds are recoupable, the letter will state the Department's intention to initiate the recoupment action against the Medi-Cal provider if the beneficiary is not promptly reimbursed. The Medi-Cal provider will be given 30 days from the date of the letter to comply with the request and provide written confirmation of the reimbursement to the beneficiary or to request a State Hearing.

   Note: If the Medi-Cal provider requests a State Hearing regarding the reimbursement decision or recoupment process, the request will be forwarded to the DSS/State Hearings Division (SHD) along with information that identifies both the Medi-Cal provider and the beneficiary who requested the reimbursement at issue in the State Hearing;

Day 16 to 60 – The Department will evaluate the healthcare provider's response to the Department's request for direct reimbursement to the beneficiary and continue processing the beneficiary's claim. If additional information is required, the claim is not complete and the reimbursement process may be delayed;

Day 60 to 120 –

- If reimbursement for the full amount has been made to the beneficiary by the healthcare provider(s) voluntarily, the Department will close the claim and send a letter to the beneficiary indicating that the claim was closed due to payment from the healthcare provider.

- If the Medi-Cal provider has not made full reimbursement, the Department will initiate recoupment from the Medi-Cal provider if appropriate.[4]

  If recoupment is appropriate, then the Department will notify the Medi-Cal provider that the Department will initiate recoupment proceedings against the Medi-Cal provider. The Department will permanently divert funds from the Medi-Cal provider sufficient to reimburse the claim in full, reimburse the beneficiary, and close the claim. The recoupment action will delay the reimbursement process timeline.

[4] Sufficient funds must be available to be permanently diverted from the enrolled provider's expected Medi-Cal payments at the time recoupment is initiated by the Department. If funds are not available from a provider for recoupment, then the Department will directly reimburse the beneficiary for the valid claim at the amount paid, not to exceed the rate established for the service under the Medi-Cal program. (California Welfare and Institutions Code, section 14019.3(i)(5).)

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If recoupment is not appropriate, the Department will directly reimburse the beneficiary for those services approved on the beneficiary's claim. Reimbursement may be up to the allowable Medi-Cal rate(s) for the specific Medi-Cal covered service(s), and shall be considered payment in full of the claim. The Department will also send a letter to the beneficiary indicating that the claim was paid along with pertinent claim payment information and information on requesting a State Hearing.

- If all or part of the beneficiary's claim is denied, the beneficiary will be sent a NOA explaining what was denied and why. The NOA will provide information on how to file for a State Hearing. The beneficiary has 90 days from the date of the NOA to request a State Hearing.

F. Criteria for Processing Beneficiary Claims

Claims must meet the following criteria in order to qualify for reimbursement. In some cases to satisfy the criteria a declaration might supplement other documentary evidence. A declaration shall not substitute for documentation of medical necessity: Claims that do not meet the following criteria will be denied:

The beneficiary was eligible for Medi-Cal at the time the service(s) was(were) provided;

The claimed service(s) was(were) provided on or after June 27, 1997;

The service(s) provided was(were) a Medi-Cal covered service—i.e., a Medi-Cal benefit at the time the service(s) was(were) rendered;

The beneficiary was eligible to receive the service(s) at the time the service(s) was(were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits;

The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.), with an itemized list of services covered by the payment, and to whom the payment was made;

The beneficiary has submitted a completed STD 204 form;

For those Medi-Cal services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider that shows medical necessity for the service(s);

The claimed cost(s) was(were) not required to meet co-payments, share of cost or other cost-sharing requirement(s);

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The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal/Denti-Cal, other Medi-Cal funded program, the healthcare provider or by a third party;

The beneficiary did not have other health coverage at the time the service(s) was(were) rendered that would have been obligated to pay the claimed cost(s);

Claims for Medi-Cal covered service(s) provided during the evaluation period for date(s) of service on or after February 2, 2006, and claims for Medi-Cal covered service(s) provided during the post approval period for date(s) of service on or after June 27, 1997, the service(s) must have been rendered by a provider who at the time the service(s) was(were) rendered was an active Medi-Cal authorized provider.

Submission timelines for a timely claim:

The claim(s) for service(s) that was(were) provided from June 27, 1997, through Month Day, Year[D1], must be received by the Department by Month Day, Year [D2],or within 90 days after issuance of the Medi-Cal card (addresses the February 8, 2006 trial court order, Issue 4), whichever is the longest period of time (to account for those claims in which the beneficiary's evaluation period was longer than a calendar year);

The claim(s) for service(s) that was(were) provided on or after Month Day, Year[D3], must be received by the Department within one calendar year after the date the service(s) was(were) rendered or within 90 days after issuance of the Medi-Cal card, whichever is the longest period of time (to account for those claims in which the beneficiary's evaluation period was longer than a calendar year) (Addresses the February 8, 2006 trial court order, Issue 4);

If either a State Hearing request or a claim was timely submitted and must be dismissed for a defect that can be cured, the Administrative Law Judge (ALJ) will refer the beneficiary back to the Department for evaluation of the claim. The ALJ's order will provide that the beneficiary may file a new or amended claim with the Department within 60 days after the issuance date of the ALJ's written dismissal decision, if the period for filing the claim is past, or within any period remaining to file a timely or amended claim, if that period is longer.

G. State Hearings- New Procedures

There are two claims adjudication outcomes that will lead to a new State Hearing procedure opportunity. This new procedure extends the State Hearing to both the beneficiary and the Medi-Cal provider. The adjudication outcomes are:

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Denial of the beneficiary's reimbursement claim based on failure to provide documentation that meets all adjudication criteria listed in Section F.

- This outcome generates a NOA and right to a State Hearing for the beneficiary.

2. Tentative reimbursement approval requiring recoupment of a Medi-Cal provider's funds.

   - This outcome generates a NOA and right to a State Hearing for the Medi-Cal provider.

1. Denial of a Claim Based on Failure to Meet All Adjudication Criteria

Claims that fail to provide documentation that meets all adjudication criteria will be denied and a NOA will be sent to the beneficiary. If the beneficiary requests a State Hearing to contest the validity of the denial, a State Hearing will be scheduled.

The hearing will include only the beneficiary and the Department, if the reason for the denial relates only to the beneficiary; i.e., the beneficiary was not eligible for Medi-Cal in the month the services were provided, the service for which reimbursement is requested is not a Medi-Cal benefit, the claim was incomplete, the request for a hearing was filed more than 90 days after the denial NOA was sent.

If the basis of the denial is an issue upon which there could be a dispute between the beneficiary and the Medi-Cal provider, the Medi-Cal provider of the service will be notified that the beneficiary has requested a hearing seeking reimbursement of funds they assert they paid to the Medi-Cal provider for Medi-Cal covered services. The Medi-Cal provider will be informed that if they contest the claim for reimbursement, they must participate in the State Hearing in order to represent their interests. The Medi-Cal provider will be informed that the State Hearing decision will result in a final decision on their obligation to reimburse the beneficiary and failure to represent their interests may subject them to recoupment actions. The Medi-Cal provider will have 30 days from the date of the notification letter to research the case and prepare arguments and evidence.

The Department will prepare a position statement that will set forth the evidence and the Department's determination of the party prevailing on the claim. The hearing will be scheduled with two weeks notice to all parties. All parties wishing to introduce documentary evidence must provide that evidence in advance of the hearing. The SHD will assure that all parties have copies of the documentary evidence prior to the hearing. At the hearing, the Department, the beneficiary, and the Medi-Cal provider will have an opportunity to present testimony and arguments in support of their position and to cross-examine witnesses presented by other parties. At the conclusion of the hearing, the record will be closed and the ALJ will issue a written decision that the parties will receive in the mail.

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The rules for State Hearing will follow the regulations set forth in the California Department of Social Services Manual of Policies and Procedures Division 22, to the extent practicable, except as otherwise provided in this Plan.

2. Ensuring Beneficiary Payments through Recoupment of a Medi-Cal Provider's Funds

In the February 8, 2006 court order, the court required the Department to amend the previous implementation plan to provide, "a detailed description of the steps and procedures the Department intends to take to 'ensure payment to a beneficiary by a provider.'" In order to comply, the Department must create a new procedure that may require recoupment of Medi-Cal funds from a Medi-Cal provider that exceed the Medi-Cal rate, if in fact the beneficiary actually paid more for a Medi-Cal covered service than the Medi-Cal maximum rate for that service. The Department has not yet promulgated regulations specific to W&I Code Section 14019.3 defining the specific mechanism to recoup funds from Medi-Cal providers including those in excess of the Medi-Cal rate. This Plan and the subsequent court order in this matter are intended to provide confirmation that the involved department or program responsible for final adjudication of a Beneficiary Reimbursement Claim has the legal authority to implement a monetary recoupment mechanism, to permanently redirect a provider's Medi-Cal reimbursement funds to satisfy an adjudicated Beneficiary Reimbursement claim including the new State Hearing process to provide joint and exclusive administrative remedy to disputes by all involved parties, until such time as the Department promulgates regulations specific to the mechanism of recoupment authorized under California Welfare and Institutions Code Section 14019.3.

The new procedures were designed to assure the beneficiary will receive either full reimbursement, or in the alternative the due process to which they are entitled while also allowing a Medi-Cal provider the right to due process to provide evidence that the proposed reimbursement and recoupment is not correct.

The current State Hearing process for beneficiaries resolves disputes involving any adverse actions related to Medi-Cal eligibility or benefits. That process was enacted pursuant to Welfare and Institutions Code, Section 10950 et. seq. That process is not a remedy for Medi-Cal providers to resolve other Medi-Cal payment/funding issues.

This new State Hearing process includes the following steps:

> The involved department or program will notify the Medi-Cal provider that the involved department or program intends to recoup funds the Medi-Cal provider received from the beneficiary in order to fully to reimburse the beneficiary. The Medi-Cal provider will be informed that it may voluntarily reimburse the beneficiary and bill Medi-Cal for the services rendered, or if it disputes the validity of reimbursement and proposed recoupment, it may request a State Hearing. The involved department or program will receive the Medi-Cal provider's State

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Hearing request and forward it to DSS along with information about the beneficiary claim so that DSS can administer the new State Hearing process.

DSS will send an acknowledgement letter to all parties to the hearing. This letter will inform parties of their right and opportunity to participate in the hearing and that a decision may be made against their interests, even if they do not participate.

A party will have 30 days to prepare for the hearing after receiving this information. A party may request additional time and upon good cause, SHD will grant additional preparation time.

The involved department or program will prepare a position statement that explains the reason for the state action and includes all claims documentation timely submitted by the beneficiary and the Medi-Cal provider. The position statement will include the involved department or program's evaluation of the documentation and the involved department or program's proposed disposition of the claim. The position statement will be mailed to the beneficiary and the Medi-Cal provider two weeks before the scheduled hearing.

The involved department or program, the beneficiary, and Medi-Cal provider will each represent their own interests at the hearing and provide documentation and testimony to support their position. Any party may designate an authorized representative to represent them in accordance with the California Department of Social Services Manual of Policies and Procedures Division 22, as applicable, and guidelines, criteria and information otherwise provided in this Plan.

All State Hearing decisions resulting in beneficiary reimbursement will be forwarded directly from DSS to the involved department or program for processing of reimbursement if so ordered. (Addresses the February 8, 2006 trial court order, Issue 3.)

The critical steps that distinguish this new State Hearing process from the current process include:

The new State Hearing process shall jointly provide the beneficiary and the Medi-Cal provider the sole and exclusive administrative remedy regarding their respective interests regarding the claim for reimbursement and the funds potentially subject to recoupment. The State Hearing will afford both the beneficiary and the Medi-Cal provider the opportunity to present evidence, through documents and/or testimony, to challenge any evidence presented against them, and to present arguments for their position. The beneficiary, Medi-Cal provider, and involved department or program are all parties to the State Hearing.

A Medi-Cal provider will be permitted 30 days from the date of the NOA regarding the intended recoupment action to request a State Hearing to contest the recoupment of Medi-Cal funds. If the court determines a longer period is required, the time within which the beneficiary's claim will be adjudicated must be extended by the same number of days.

A State Hearing to determine the correctness of the involved department or program determination regarding the reimbursement claim and recoupment action may be held by telephone, unless in the discretion of the ALJ, the interests of justice require a videoconference or in person hearing. The primary relevant evidence in these cases will be documents, and all parties will have all evidence in hand at the time of the hearing.

A postponement or continuance of the State Hearing granted to one party will extend, by an equal number of days, the date by which a final decision to all parties is due in the case.

A request for a State Hearing tolls the beneficiary's 120-day payment timeline for reimbursement of a completed claim to determine if evidence submitted by the Medi-Cal provider rebuts the beneficiary claim.

A requirement that both the Medi-Cal provider and the beneficiary must agree to withdraw a hearing request and if one party disagrees, the State Hearing will proceed.

The Medi-Cal provider may authorize a "designated hearing representative" to present their evidence; this may be an attorney, employee of their practice/company, or anyone else.

The SHD shall have the authority to adopt such other procedures and process as are advisable or required for the conduct and adjudication of the beneficiary reimbursement State Hearings by All County Letter (ACL.) Any ACL setting forth SHD procedures for beneficiary reimbursement hearings shall have the force and effect of law from the time the ACL is issued for 30 months. At the end of that period, the SHD must adopt regulations setting forth the procedures and processes for the beneficiary reimbursement hearings.

The Medi-Cal provider and the beneficiary will have the joint and exclusive opportunity to have the matter adjudicated by an ALJ. At the hearing evidence will be taken and discretion in the determination of facts will be vested in the ALJ. After the record is closed the ALJ shall issue an administrative decision. The reimbursement and recoupment process will be stayed pending the outcome of the State Hearing. Any appeal of the final decision by the beneficiary and/or the Medi-Cal provider shall proceed under California Code of Civil Procedure, section 1094.5.

The involved department or program may implement this new procedure through the establishment of guidelines, criteria and information bulletins published in Medi-Cal Provider Manuals, Medi-Cal Provider Bulletins, ACL, Beneficiary Notices, and Medi-Cal beneficiary publications. Pursuant to W&I Code, section 14019.3(j), "Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, this section may be implemented with a provider bulletin or similar notification, without any further regulatory action."

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State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

IF YOU WERE ELIGIBLE FOR MEDI-CAL ANYTIME SINCE JUNE 27, 1997, OR ARE ELIGIBLE NOW MEDI-CAL MAY REIMBURSE YOU FOR MEDICAL OR DENTAL BILLS YOU PAID

Conlan v. Bontá; Conlan v. Shewry

As the result of two court decisions, you may be able to be repaid for some medical expenses you paid. The California Department of Health Services (CDHS) will assist you in getting your money back if all criteria below are met:

1. You received a medically necessary medical or dental service during one or all of these time periods:
   - ✓ The 3-month period prior to the month you applied for the Medi-Cal program;
   - ✓ From the date you applied for the Medi-Cal program until the date your Medi-Cal card was issued,
   - ✓ After your Medi-Cal card was issued (includes excess co-payment and excess share of cost charges), and
2. You paid for your medical or dental service; or another person paid for your medical or dental service on your behalf. You will be asked to provide proof that the medical or dental service was paid for by you or the other person, and
3. You received the medical or dental service from a Medi-Cal enrolled provider (note: you do not need to have received the service from a Medi-Cal enrolled provider if you received the medical or dental service during the 3-month period prior to applying to Medi-Cal, or you received the services on or after June 27, 1997 but before February 2, 2006 and you had applied for Medi-Cal but not yet received a Medi-Cal card), and
4. For those Medi-Cal services that were provided and would have required Medi-Cal authorization, you have documentation from the medical or dental provider that shows medical necessity for the service, and
5. You were Medi-Cal eligible to receive that specific medical or dental service, and
6. The medical or dental service was a benefit under the Medi-Cal program, and
7. The medical or dental service was provided on or after June 27, 1997, and
8. After you received your Medi-Cal card, you contacted your provider and showed your provider your Medi-Cal card and the provider would not give you your money back.

Important dates and time frames:

- For services received June 27, 1997 through Month Day, Year[pf1], you must submit your claim by Month Day, Year [pf2]or within 90 days after issuance of the Medi-Cal card, which ever is longer.
- For services received on or after Month Day, Year[pf3],, you must submit your claim within one year of receipt of services or within 90 days after issuance of the Medi-Cal card, which ever is longer.

For more information or to file a claim, you MUST call or write to Medi-Cal at:

For Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims:	**For Dental Claims:**
California Department of Health Services Beneficiary Services P.O. Box 13008 Sacramento, CA 95813-9998 **(916) 403-2007 TDD: (916) 635-6491**	Denti-Cal Beneficiary Services P.O. Box 15539 Sacramento, CA 95852-1539 **(916) 403-2007 TDD: (916) 635-6491**

-- DON'T FORGET TO KEEP ALL RECEIPTS FOR THE MEDICAL AND DENTAL CARE YOU RECEIVE --

Medi-Cal will review your claim for repayment and send you a letter with a check or a denial letter that tells you the reason for denial. If Medi-Cal denies your request for payment, you may ask for a fair hearing. The denial letter will tell you how to ask for a fair hearing.

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Medicare/Medi-Cal Coverage: Starting January 1, 2006, medications covered under Medicare Part D will not be a covered benefit under the Medi-Cal Program and are not eligible for reimbursement. For questions regarding Medicare Part D contact 1-800-Medicare.

SI USTED ERA ELEGIBLE PARA MEDI-CAL EN CUALQUIER MOMENTO DESDE EL 27 DE JUNIO DE 1997, O AHORA ES ELEGIBLE, ES POSIBLE QUE MEDI-CAL LE REEMBOLSE POR CUENTAS MÉDICAS O DENTALES QUE USTED HAYA PAGADO

Conlan v. Bontá; Conlan v. Shewry

Como resultado de dos decisiones de la corte, es posible que usted pueda ser reembolsado/a por algunos costos médicos que usted pagó. El Departamento de Servicios de Salud de California (California Department of Health Services-CDHS) le asistirá en conseguir el reembolso de su dinero si satisface todos los requisitos mencionados abajo:

1. Usted recibió un servicio médico o dental que fue médicamente necesario durante uno o todos estos periodos:
   - ✓ En el período de 3 meses antes del mes que usted solicitó para el programa de Medi-Cal;
   - ✓ A partir de la fecha que usted solicitó para el programa de Medi-Cal hasta que su tarjeta de Medi-Cal fue expedida,
   - ✓ Después de que se expida su tarjeta médica (incluye exceso del co-pago y exceso de cargos de parte del costo, y
2. Usted pagó por su servicio médico o dental; o
   otra persona pagó por su servicio médico o dental de parte de usted (le pedirán proveer la prueba del servicio médico o dental que fue pagado por usted o por la otra persona, tal como un recibo o un cheque cancelado con una lista detallada de los servicios cubiertos por el pago), y
3. Usted recibió el servicio médico o dental de un proveedor inscrito en Medi-Cal (nota: usted no necesita haber recibido el servicio de un proveedor inscrito en Medi-Cal si usted recibió el servicio médico o dental durante el período de tres meses antes de solicitar Medi-Cal), y
4. Usted tiene una receta médica, orden o nota de un proveedor médico o dental, o evaluación de sus necesidades del programa Servicios de Casa y Cuidado Personal (In-Home Supportive Services) del condado por el servicio médico o dental que usted recibió y cuál usted pagó (a excepción de una visita de oficina con el médico/dentista, que no requiere una receta médica), y
5. Usted tenia elegibilidad de Medi-Cal para recibir ese servicio especifico médico o dental, y
6. El servicio médico o dental fue un beneficio bajo el programa de Medi-Cal, y
7. El servicio médico o dental fue proporcionado en o después del 27 de junio de 1997, y
8. Después de que usted recibió su tarjeta de Medi-Cal, usted contactó a su proveedor y le demostró a su proveedor su tarjeta de Medi-Cal y el proveedor no le reembolsó su dinero.

Fechas y marcos de tiempo importantes:

- Para los servicios recibidos el 27 de junio de 1997 al ~~30 de septiembre del 2006~~, usted debe presentar su reclamo antes del ~~1º de octubre del 2007~~, o en el plazo de 90 días después de que se expida la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.
- Para los servicios recibidos en o después del ~~1º de octubre del 2006~~, usted debe presentar su reclamo dentro del plazo de un año de la fecha que recibió los servicios, o en el plazo de 90 días después de que se expida la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.

Para más información o presentar un reclamo, usted DEBE llamar o escribir a Medi-Cal al:

Para Reclamos Médicos, de Salud Mental, de Drogas y Alcohol, y de Servicios de Casa y Cuidado Personal (Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Service Claims): California Department of Health Services Beneficiary Services P.O. Box 13008 Sacramento, CA 95813-9998 **(916) 403-2007 TDD: (916) 635-6491**	**Para Reclamos Dentales (Dental Claims):** Denti-Cal Beneficiary Services P.O. Box 15539 Sacramento, CA 95852-1539 **(916) 403-2007 TDD: (916) 635-6491**

--NO SE OLVIDE DE GUARDAR TODOS LOS RECIBOS DEL CUIDADO MÉDICO Y DENTAL QUE USTED RECIBE--
Medi-Cal revisará su reclamo para el reembolso y le enviará una carta con un cheque o una carta de negación que le explicará la razón del porqué fue negado/a. Si Medi-Cal niega su pedido de pago, usted puede pedir una audiencia justa. La carta de negación le dirá cómo pedir una audiencia justa.

Cobertura de Medicare/Medi-Cal: Empezando el 1º de enero del 2006, las medicaciones cubiertas bajo Medicare Parte D no serán un beneficio cubierto bajo el programa de Medi-Cal y estas medicaciones no son elegibles para el reembolso. Para las preguntas con respecto a Medicare Parte D llame al 1-800-Medicare.

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SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

KEVIN CONLAN, ASHER SCHWARZMER and THOMAS STEVENS,

Petitioners,

v.

SANDRA SHEWRY, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES; CALIFORNIA DEPARTMENT OF HEALTH SERVICES, et al.,

Respondents.

CASE NO. 987697

~~[proposed]~~ ORDER APPROVING RESPONDENTS' REVISED IMPLEMENTATION PLAN AND PROPOSED NOTICE TO BENEFICIARIES

Good cause appearing, Respondents' Revised Implementation Plan and Proposed Notice to Beneficiaries as submitted to this Court are hereby approved. Respondents may proceed to distribute the Notice to Beneficiaries and implement the Revised Implementation Plan.

The start date for the Revised Implementation Plan shall be November 16, 2006 Accordingly, the dates set forth in the Revised Implementation Plan at page 9 (D1, D2, D3) shall be as follows: D1: November 16, 2006; D2: November 16, 2007; and D3: November 16, 2006.

Respondents shall provide reports to petitioners, with copies to the Court, twice per year for the next two years, that will include at least the following information regarding the claims submitted under the Plan

1. The number of completed claims received by the California Department of Health Services (CDHS) under the Plan.

2. The number of claims redirected to sister agencies by CDHS;

3. The number of fee-for-service claims paid by CDHS; and

4. The number of fee-for-service claims denied by CDHS.

The Court shall retain jurisdiction over this matter for all purposes for two years from the date of this order

IT IS SO ORDERED.

DATED: 11/17/06

PETER J. BUSCH
The Hon. Peter J. Busch
Judge of the Superior Court

11-17-06
Approved as to Form
Michael Keys

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

IF YOU WERE ELIGIBLE FOR MEDI-CAL ANYTIME SINCE JUNE 27, 1997, OR ARE ELIGIBLE NOW, MEDI-CAL MAY REIMBURSE YOU FOR MEDICAL OR DENTAL BILLS YOU PAID

Conlan v. Bontá; Conlan v. Shewry

As the result of two court decisions, you may be able to be repaid for some medical expenses you paid. The California Department of Health Services (CDHS) will assist you in getting your money back if all criteria below are met:

1. You received a medically necessary medical or dental service during one or all of these time periods:
   - ✓ The 3-month period prior to the month you applied for the Medi-Cal program,
   - ✓ From the date you applied for the Medi-Cal program until the date your Medi-Cal card was issued,
   - ✓ After your Medi-Cal card was issued (includes excess co-payment and excess share of cost charges).
2. You paid for your medical or dental service; or another person paid for your medical or dental service on your behalf. You will be asked to provide proof that the medical or dental service was paid for by you or the other person.
3. You received the medical or dental service from a Medi-Cal enrolled provider (note: you do not need to have received the service from a Medi-Cal enrolled provider if you received the medical or dental service during the 3-month period prior to applying to Medi-Cal, or you received the services on or after June 27, 1997 but before February 2, 2006 and you had applied for Medi-Cal but not yet received a Medi-Cal card).
4. For those Medi-Cal services that were provided and would have required Medi-Cal authorization, you have documentation from the medical or dental provider that shows medical necessity for the service.
5. You were Medi-Cal eligible to receive that specific medical or dental service.
6. The medical or dental service was a benefit under the Medi-Cal program.
7. The medical or dental service was provided on or after June 27, 1997.
8. After you received your Medi-Cal card, you contacted your provider and showed your provider your Medi-Cal card and the provider would not give you your money back.

Important dates and time frames:

- For services received June 27, 1997 through November 16, 2006, you must submit your claim by November 16, 2007, or within 90 days after issuance of the Medi-Cal card, which ever is longer.
- For services received on or after November 16, 2006, you must submit your claim within one year of receipt of services or within 90 days after issuance of the Medi-Cal card, which ever is longer.

For more information or to file a claim, you MUST call or write to Medi-Cal at:

For Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims:	For Dental Claims:
California Department of Health Services **Beneficiary Services** **P.O. Box 138008** **Sacramento, CA 95813-8008** **(916) 403-2007 TDD: (916) 635-6491**	**Denti-Cal** **Beneficiary Services** **P.O. Box 526026** **Sacramento, CA 95852-6026** **(916) 403-2007 TDD: (916) 635-6491**

-- DON'T FORGET TO KEEP ALL RECEIPTS FOR THE MEDICAL AND DENTAL CARE YOU RECEIVE --

Medi-Cal will review your claim for repayment and send you a letter with a check or a denial letter that tells you the reason for denial. If Medi-Cal denies your request for payment, you may ask for a state hearing. The denial letter will tell you how to ask for a state hearing.

Medicare/Medi-Cal Coverage: Starting January 1, 2006, medications covered under Medicare Part D will not be a covered benefit under the Medi-Cal Program and are not eligible for reimbursement. For questions regarding Medicare Part D contact 1-800-Medicare.

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State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

SI USTED ERA ELEGIBLE PARA MEDI-CAL EN CUALQUIER MOMENTO DESDE EL 27 DE JUNIO DE 1997, O AHORA ES ELEGIBLE, ES POSIBLE QUE MEDI-CAL LE REEMBOLSE POR CUENTAS MÉDICAS O DENTALES QUE USTED HAYA PAGADO

Conlan v. Bontá; Conlan v. Shewry

Como resultado de dos decisiones de la corte, es posible que usted pueda ser reembolsado/a por algunos costos médicos que usted pagó. El Departamento de Servicios de Salud de California (California Department of Health Services-CDHS) le asistirá en conseguir el reembolso de su dinero si satisface todos los requisitos mencionados abajo:

1. Si usted recibió un servicio médico o dental que fue médicamente necesario durante estos períodos:
   - ✓ En el período de 3 meses antes del mes que usted solicitó para el programa de Medi-Cal,
   - ✓ A partir de la fecha que usted solicitó el programa de Medi-Cal hasta que su tarjeta de Medi-Cal fue expedida,
   - ✓ Después de que se expida su tarjeta médica (incluye exceso del pago parcial y exceso de cargos de parte del costo).
2. Si usted pagó por su servicio médico o dental, u otra persona pagó por su servicio médico o dental de parte suya. Usted va ser requerido que provea pruebas del servicio medico o dental, que fue pagado por usted u otra persona.
3. Si usted recibió el servicio médico o dental de un proveedor inscrito en Medi-Cal (nota: usted no necesita haber recibido el servicio de un proveedor inscrito en Medi-Cal si usted recibió el servicio médico o dental durante el período de tres meses antes de solicitar Medi-Cal).
4. Si usted tiene, una autorización de un proveedor médico o dental, y tienes documentación del proveedor medico o dental que enseña que los servicios fueron necesarios.
5. Si usted tenía elegibilidad de Medi-Cal para recibir ese servicio específico médico o dental.
6. El servicio médico o dental fue un beneficio bajo el programa de Medi-Cal.
7. El servicio médico o dental fue proporcionado en o después del 27 de junio de 1997.
8. Después de que usted recibió su tarjeta de Medi-Cal, usted contactó a su proveedor y le mostró a su proveedor su tarjeta de Medi-Cal y el proveedor no le reembolsó su dinero.

Fechas y horarios importantes:

- Para los servicios recibidos el 27 de junio de 1997 al 16 de noviembre del 2006, usted debe presentar su reclamo antes del 16 de noviembre del 2007, o en el plazo de 90 días después de que se recibió la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.
- Para los servicios recibidos en o después del 16 de noviembre del 2006, usted debe presentar su reclamo dentro del plazo de un año de la fecha que recibió los servicios, o en el plazo de 90 días después de que se recibió la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.

Para más información o presentar un reclamo, usted DEBE llamar o escribir a Medi-Cal a las siguientes direcciones

Para Reclamos Médicos, de Salud Mental, de Drogas y Alcohol, y de Servicios de Casa y Cuidado Personal (Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Service Claims):
California Department of Health Services
Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008
(916) 403-2007 TDD: (916) 635-6491

Para Reclamos Dentales (Dental Claims)

Denti-Cal
Beneficiary Services
P.O. Box 526026
Sacramento, CA 95852-6026
(916) 403-2007 TDD: (916) 635-6491

--NO SE OLVIDE GUARDAR TODOS LOS RECIBOS DEL LOS SERVICOS MÉDICO Y DENTAL QUE USTED RECIBIO--

Medi-Cal revisará su reclamo para el reembolso y le enviará una carta con un cheque o una carta de negación que le explicará la razón del porqué fue negado. Si Medi-Cal niega su petición de pago, usted puede pedir una Apelación al Estado. La carta de negación le dirá cómo pedir la Apelación al Estado.

Cobertura de Medicare/Medi-Cal: Empezando el 1º de Enero del 2006, los medicamentos cubiertas bajo Medicare Parte D no serán un beneficio cubierto bajo el programa de Medi-Cal y estos medicamentos no son elegibles para el reembolso. Para preguntas sobre Medicare Parte D llame al 1-800-Medicare.

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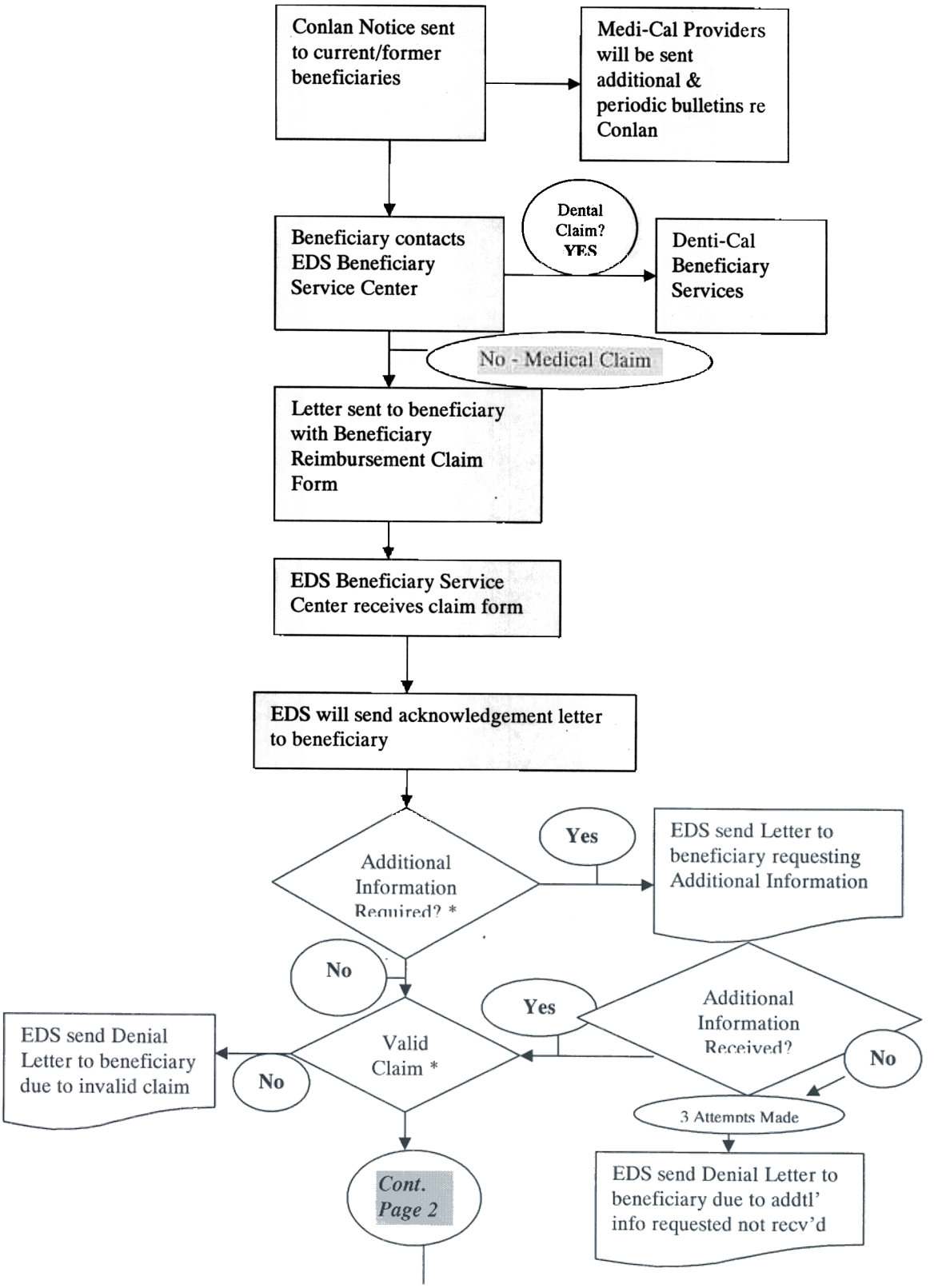
Medi-Cal Managed Care
Conlan Claim Process



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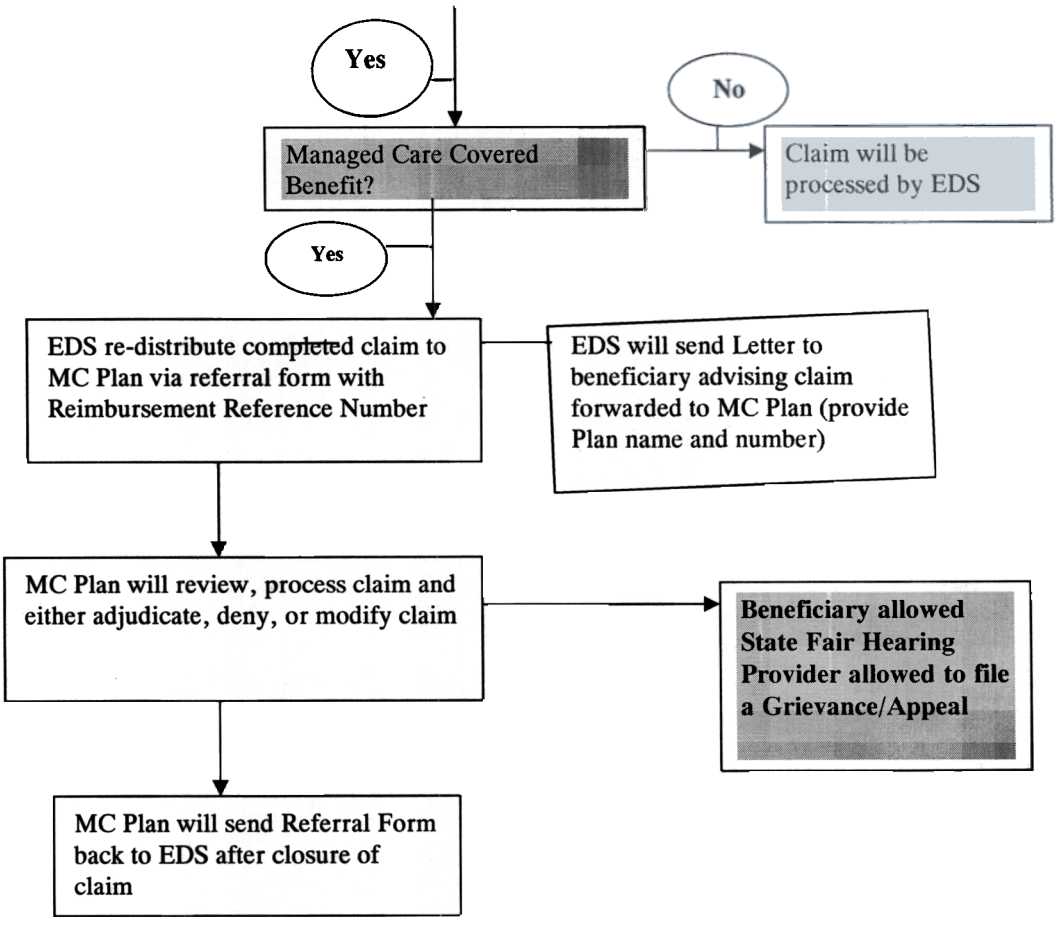
Medi-Cal Managed Care
Conlan Claim Process



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Beneficiary Reimbursement Claim Referral

Claim Referred To:

☐ ADP ☐ DMH ☐ IHSS ☐ Dental ☐ Managed Care

CRM Issue #:_____

Date Claim Received:_____ Payment Due Date:

Claim Information

Beneficiary Name:_____

Address:_____

Date(s) of Service_____ _____

Procedure Code(s)_____ _____

Beneficiary Paid Amount:$_____

Medi-Cal Rate:$_____

Medi-Cal Provider? Y N

Provider Number:_____

COMMENTS:_____

_____

_____

Analyst:_____ Phone #:_____

Program Use Only

Date Case Received:_____

☐ Paid Payment Date:_____ Amount Paid:_____

☐ Denied Denial Date:_____

Denial Reason:_____

Analyst: _____ Phone #:_____

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State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 13, 2020

ALL PLAN LETTER 20-013

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: PROPOSITION 56 DIRECTED PAYMENTS FOR FAMILY PLANNING SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed health care plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified family planning services with dates of service on or after July 1, 2019.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the California Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill (AB) 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-101-3305 appropriates Proposition 56 funding to support family planning services for Medi-Cal beneficiaries, which DHCS is implementing in managed care in the form of a directed payment arrangement for specified family planning services in accordance with DHCS' developed payment methodology outlined below.[2] On June 30, 2019, DHCS requested approval from the federal Centers for Medicare & Medicaid Services (CMS) for this directed payment arrangement in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c)(2).[3] CMS approval of this directed payment arrangement is still pending.

Subject to future budgetary authorization and appropriation by the California Legislature and the necessary federal approvals of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis for the duration

[1] This APL does not apply to Prepaid Ambulatory Health Plans or Rady Children's Hospital.
[2] AB 74 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB74.
[3] Part 438 of the CFR can be accessed at: https://www.ecfr.gov/cgi-bin/text-idx?SID=c131f365759360ca3555585f2b6a1b6e&mc=true&node=pt42.4.438&rgn=div5.

of the program. The requirements of this APL may change, if required, to obtain CMS approval for this directed payment arrangement or to comport with future State legislation.

This directed payment program is intended to enhance the quality of patient care by ensuring that Providers in California who offer family planning services receive enhanced payment for their delivery of effective, efficient, and affordable health care services. Timely access to vital family planning services is a critical component of beneficiary and population health. In particular, this program is focused on the following categories of family planning services:

- Long-acting contraceptives
- Other contraceptives (other than oral contraceptives) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures (for females and males)

Under federal law,[4] "a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive such [family planning] services under Section 1396d(a)(4)(C) of this title…."[5] Therefore, Members must be allowed freedom of choice of family planning Providers, and may receive such services from any qualified family planning Provider, including out-of-Network Providers, without the need to obtain prior authorization. DHCS managed care contracts specify the requirements pertaining to family planning services in Exhibit A, Attachment 9, Access and Availability.[6]

POLICY:
Subject to obtaining the necessary federal approvals and budgetary authorization and appropriation by the California Legislature, DHCS is requiring MCPs, either directly or through their delegated entities and Subcontractors, to pay qualified contracted and non-contracted Providers[7] a uniform and fixed dollar add-on amount for the specified

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[4] *See* Title 42 of the United States Code (U.S.C.), Section 1396a(a)(23)(B).
[5] "[F]amily planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies[.]" 42 U.S.C. Section 1396d(a)(4)(C).
[6] MCP boilerplate contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[7] A qualified Provider is a Provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish family planning

family planning services (listed below) provided to a Medi-Cal managed care member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D), with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint for this program, which will be made available on DHCS' Directed Payments Program website upon CMS approval.[8]

MCPs are responsible for ensuring that qualifying family planning services are reported to DHCS in encounter data pursuant to APL 14-019, "Encounter Data Submission Requirements" using the procedure codes in the table below. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided. MCPs must include oversight in their utilization management processes, as appropriate. The uniform dollar add-on amounts of the directed payments vary by procedure code:

Procedure Code[9]	Description	Uniform Dollar Add-on Amount
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	$2,727.00
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00
J3490U8	DEPO-PROVERA	$340.00
J7303	CONTRACEPTIVE VAGINAL RING	$301.00
J7304	CONTRACEPTIVE PATCH	$110.00

services to a member. *See* Title 22 California Code of Regulations (CCR), Section 51200. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.

[8] The preprint will be available upon approval by CMS. DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

[9] Services billed for the following Current Procedural Terminology codes with modifiers UA or UB are excluded from these directed payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.

J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00
11976	REMOVE CONTRACEPTIVE CAPSULE	$399.00
11981	INSERT DRUG IMPLANT DEVICE	$835.00
58300	INSERT INTRAUTERINE DEVICE	$673.00
58301	REMOVE INTRAUTERINE DEVICE	$195.00
81025	URINE PREGNANGY TEST	$6.00
55250	REMOVAL OF SPERM DUCT(S)	$521.00
58340	CATHETER FOR HYSTEROGRAPHY	$371.00
58555	HYSTEROSCOPY DX SEP PROC	$322.00
58565	HYSTEROSCOPY STERILIZATION	$1,476.00
58600	DIVISION OF FALLOPIAN TUBE	$1,515.00
58615	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00
58661	LAPAROSCOPY REMOVE ADNEXA	$978.00
58670	LAPAROSCOPY TUBAL CAUTERY	$843.00
58671	LAPAROSCOPY TUBAL BLOCK	$892.00
58700	REMOVAL OF FALLOPIAN TUBE	$1,216.00

The uniform dollar add-on amounts for these family planning services must be in addition to whatever other payments eligible Providers would normally receive from the MCP, or the MCP's delegated entities and Subcontractors. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs,[10] and Cost-Based Reimbursement Clinics[11] are not eligible to receive this uniform dollar add-on directed payment.

[10] MCP contract, Exhibit E, Attachment 1, Definitions.
[11] Cost-Based Reimbursement Clinics are defined in Welfare and Institutions Code Section 14105.24, which is located at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14105.24&lawCode=WIC, as well as Supplement 5 to Attachment 4.19-B of the State Plan, which is located at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement%205%20to%20Attachment%204.19-B.pdf.

Data Reporting

Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, procedure code, service month, payor (i.e., MCP, delegated entity, or Subcontractor), and the Provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports shall be submitted in a consumable file format (i.e., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager.

MCPs must submit updated reports each subsequent quarter in the same format as the initial submission until the MCP considers the report to be complete. Each updated report must replace any prior reports. MCPs must submit the updated quarterly report in the appropriate file format and include an attestation that the MCP considers the report complete.

MCPs must continue to submit encounter data for the specified procedure codes as required by DHCS; however, there are no new encounter data submission requirements associated with this APL.

Payment and Other Financial Provisions

For clean claims or accepted encounters with dates of service between July 1, 2019, and the date the MCP receives payment from DHCS, the MCP must ensure that payments required by this APL are made within 90 calendar days of the date the MCP receives payments accounting for the projected value of the directed payments from DHCS. From the date the MCP receives payment onward, the MCP must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim[12] or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for applicable family planning services received by the MCP more than one (1) year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the affected Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances

[12] A "clean claim" is defined in 42 CFR Section 447.45(b).

related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Providers. This communication must, at a minimum, include a description of how payments will be processed, how to file a grievance, and how to determine who the payor will be.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement shall be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint, which will be made available on the DHCS' Directed Payments Program website upon CMS approval. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

MCPs are further responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and Subcontractors.

Subject to future budgetary authorization and appropriation by the California Legislature and CMS approval of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis in future years. Please note that the requirements of this APL may change if required for CMS approvals applicable to this directed payment arrangement or as required in future budgetary authorization and appropriation by the California Legislature.

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 15, 2020

ALL PLAN LETTER 20-014

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: PROPOSITION 56 VALUE-BASED PAYMENT PROGRAM DIRECTED PAYMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on value-based directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), to Network Providers for qualifying services tied to performance on designated health care quality measures in the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-103-3305 appropriates Proposition 56 funds for State Fiscal Year (SFY) 2019-20, SFY 2020-21, and SFY 2021-22, pursuant to Welfare and Institutions Code (WIC) section 14188.1, including a portion to be used for directed payments in managed care according to the DHCS-developed payment methodology outlined below.[2]

Senate Bill 78 (Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2019) added Article 5.8 (commencing with section 14188) to WIC. In alignment with the Governor's Budget, this article requires DHCS to develop a value-based payment (VBP) program for the managed care delivery system to provide payments to Network Providers aimed at improving health care in the domains of prenatal and postpartum

[1] This APL does not apply to Prepaid Ambulatory Health Plans, Rady Children's Hospital, or SCAN Health Plan.
[2] California Law is searchable at http://leginfo.legislature.ca.gov/faces/codes.xhtml.

care, early childhood prevention, chronic disease management, and behavioral health care.[3]

On January 17, 2019, DHCS issued APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, which describes how DHCS evaluates Network Provider status and establishes requirements that must be satisfied in order for Network Providers to be eligible for directed payments.[4]

On June 21, 2019, DHCS released the VBP program specifications outlining the measures and payment triggers for each domain on the "Value Based Payment Program" webpage on the DHCS website.[5] The specifications provide an explanation for each VBP program measure, the source for each measure, and the appropriate procedure codes.[6] DHCS selected the measures in each domain in coordination with various professional and medical organizations and considered several factors, including but not limited to, stakeholder and advocate feedback, whether or not a measure aligns with DHCS' quality efforts, the number of impacted Members, and whether or not sufficient administrative support is available for the measure.

On June 30, 2019, DHCS requested approval from the Centers for Medicare and Medicaid Services (CMS) to implement this directed payment arrangement, in accordance with Title 42 of the Code of Federal Regulations (CFR) section 438.6(c)(2).[7] DHCS will make the CMS-approved preprint available on the "Directed Payments Program" webpage on the DHCS website upon CMS approval.[8]

POLICY:
Subject to obtaining the necessary federal approvals and consistent with 42 CFR section 438.6(c), MCPs, either directly or through their delegated entities and Subcontractors, must make directed payments for qualifying VBP program services (as defined below) for dates of service on or after July 1, 2019, in the specified amounts for the appropriate procedure codes, in accordance with the CMS-approved preprint. The directed payments shall be in addition to whatever other payments eligible Network

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[3] WIC sections 14188–14188.4.
[4] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[5] DHCS' Value Based Payment Program webpage is available at: https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx.
[6] The VBP program specifications are outlined in the *Value Based Payment Program Performance Measures* specifications, available at: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-05.07.20.pdf.
[7] The CFR is searchable at: https://www.ecfr.gov/cgi-bin/ECFR?page=browse.
[8] DHCS' Directed Payments Program webpage is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

Providers would normally receive from the MCP or the MCP's delegated entities and Subcontractors.

VBP Program Domains, Measures, and Qualifying Services

MCPs must make value-based directed payments to eligible Network Providers for specific qualifying services tied to performance across four domains, as set forth in the VBP program specifications and the valuation summary.[9] The domains and measures eligible for directed payments and the corresponding amounts for qualifying services are:

Domain	Measure	Add-On Amount for Non-At-Risk Members	Add-On Amount for At-Risk Members[10]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
	Prenatal Care Visit	$70.00	$105.00
	Postpartum Care Visits	$70.00	$105.00
	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
	All Childhood Vaccines for Two Year Olds	$25.00	$37.50

[9] The VBP valuation summary is outlined in the "Proposition 56 Value Based Payment Program Measure Valuation Summary," available at: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-VS.pdf.

[10] For qualifying events tied to Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, MCPs must make the add-on directed payments corresponding to at-risk Members. For qualifying events tied to all other Members, MCPs must make the add-on directed payments corresponding to non-at-risk Members.

	Blood Lead Screening	$25.00	$37.50
	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
	Diabetes Care	$80.00	$120.00
	Control of Persistent Asthma	$40.00	$60.00
	Tobacco Use Screening	$25.00	$37.50
	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
	Management of Depression Medication	$40.00	$60.00
	Screening for Unhealthy Alcohol Use	$50.00	$75.00

A qualifying service is a specific service, as set forth in the VBP program specifications, that is provided by an eligible Network Provider (see below) on or after July 1, 2019, to a Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). MCPs must ensure that qualifying services reported using the procedure codes indicated in the VBP program specifications are appropriate for the services being provided. Additionally, MCPs must report the qualifying services using the appropriate procedure codes in their encounter data submissions and provider network data submissions to DHCS.[11, 12] As MCPs are required to periodically report member-specific immunization information to an immunization registry, the California Immunization Registry (CAIR) will be used as a supplemental data source for the vaccine-related measures.[13, 14]

[11] For more information on encounter data, see APL 14-019: Encounter Data Submission Requirements, or any future iteration of that APL.
[12] For more information on provider network data, see APL 16-019: Managed Care Provider Data Reporting Requirements, or any future iteration of that APL.
[13] For more information on immunization requirements, see APL 18-004: Immunization Requirements or any future iteration of that APL.
[14] The CAIR website is available at: http://cairweb.org/

MCPs must make VBP directed payments for qualifying services provided by eligible Network Providers with dates of service on or after July 1, 2019, in accordance with the requirements outlined within the VBP program specifications. If applicable, for purposes of VBP directed payments, the "measurement year" for a given service is the calendar year in which that service was provided.

Network Providers Eligible for VBP Program Payments

Individual rendering Network Providers qualified to provide the VBP program services are eligible to receive VBP directed payments. In addition to the requirements outlined in APL 19-001, Network Providers must meet the following criteria to be eligible for the payments outlined above:

- Possess an individual (Type 1) National Provider Identifier (NPI); and
- Be practicing within their practice scope.

Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics (as defined in Supplement 5 to Attachment 4.19-B of California's Medicaid State Plan[15] and WIC section 14105.24) are not eligible Network Providers for the purposes of the VBP program. Services provided at or by these ineligible provider types are not eligible to receive VBP directed payments.

Data Reporting

Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, VBP measure, service month, payer (i.e., MCP, delegated entity, or Subcontractor), and the Provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports shall be submitted in a consumable file format (i.e., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager.

Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, MCPs must submit an attestation to DHCS stating that no updated information is available. If updated information is available for the quarterly report, MCPs must submit the updated quarterly report in the

[15] Attachment 4.19-B of California's Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Attachment419-B.aspx.

appropriate file format and include an attestation that the MCP considers the report complete.

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim[16] or accepted encounter for a qualifying VBP program service, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying VBP program services received by the MCP more than one year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the Network Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Network Provider grievances related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Network Providers. This communication must, at a minimum, include a description of the minimum requirements for a qualifying service, how payments will be processed, how to file a grievance, and how to determine the responsible payer.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement shall be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint, which will be made available on the DHCS "Directed Payments Program" webpage upon CMS approval. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. MCPs must communicate these requirements to all delegated entities and Subcontractors.

Please note that the requirements of this APL may change based upon future budgetary authorization and appropriation by the California Legislature or the status of the required CMS approvals applicable to this directed payment arrangement.

[16] A "clean claim" is defined in 42 CFR section 447.45(b).

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Table of Contents

State/Territory Name: California

State Plan Amendment (SPA) #: 20-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

October 15, 2020

Jacey Cooper
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: TN 20-0009

Dear Ms. Cooper:

We have reviewed the proposed California State Plan Amendment (SPA) to Attachment 4.19-B, CA-20-0009, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on August 17, 2020. This SPA, effective July 1, 2020, allows for the continuation of an add-on to the fee-for-service (FFS) fee schedule rates for eligible ground emergency medical transports (GEMT) provided to Medi-Cal patients.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Blake Holt at 415-744-3754 or blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20-0009

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY 2020 $ 5.074 (in thousands)
b. FFY 2021 $ 15,221 (in thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29 to Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2020 and June 30, 2021.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Jacey Cooper

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: August 17, 2020

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:

18. DATE APPROVED: 10/15/2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2020

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Todd McMillion

22. TITLE: Director, Division of Reimbursement Review

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

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 Healthcare Common Procedure Coding System (HCPCS) Codes, as described below, effective July 1, 2019 through June 30, 2020, and July 1, 2020 through June 30, 2021. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with HCPCS Codes A0429 BLS Emergency, A0427 ALS Emergency, and A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For SFYs 2019-20 and 2020-21, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the HCPCS Code. The resulting total payment amount for HCPCS Codes A0429, A0427, A0433, and A0434 is $339.00, and for HCPCS Code A0225 is $400.72. The add-on is paid for each eligible HCPCS Code on a per-claim basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount listed in the table above for HCPCS Codes A0429, A0427, A0433, A0434 and A0225 are considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion
DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

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M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Belinda Abeyta, Executive Director, Operations (714) 246-8400
Ladan Khamseh, Chief Operations Officer, (714) 246-8400

Recommended Actions

1. Approve CalOptima Medi-Cal Policy FF.2012: *Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services* 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.2012;

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.2012; and

4. Approve modifications of the following Claims Administration Policies and Procedures:
   A. FF. 1002: CalOptima Medi-Cal Fee Schedule
   B. FF. 1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group

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 staff has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and ground emergency medical transportation (GEMT). 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 12/31/2020	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
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 adoption of Medi-Cal policy FF.2012: *Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services*, which has been drafted to address the above-listed qualifying services. This new policy defines Directed Payments and establishes requirements pursuant to which CalOptima will administer Directed Payments for qualifying services rendered to CalOptima Direct and shared risk group members. For shared risk group members, the policy will only apply to Directed Payments for GEMT services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR). CalOptima will follow DHCS guidelines, including APLs or as specified by DHCS through other correspondence, regarding qualifying services, eligible providers, and payment requirements for applicable DOS. Staff anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are established by DHCS or when DHCS subsequently changes existing Directed Payment program requirements, rates, and/or codes.

Staff seeks authority to amend, as necessary and appropriate, CalOptima Medi-Cal Fee-For-Service Physician Contracts and Shared Risk Group Contracts, to reflect that Directed Payments will be made pursuant to CalOptima Policy and Procedures.

Staff also seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2012 before funding is received from DHCS. For certain Directed Payments, such as the new Proposition 56 program for developmental screening services, DHCS expected managed care health plans, including CalOptima, to make Directed Payments for dates of service on or after January 1, 2020 before receipt of funding from DHCS. DHCS final APL for developmental screening services was released in December 2019, however, CalOptima did not receive funding from DHCS until April 2020. Further, per the APL, DHCS intends to renew the directed payment arrangement on an annual basis for the duration of the program. Considering that APLs for subsequent years might include changes in rates or codes, staff believes issuance of Directed Payments prior to CalOptima's receipt of funding from DHCS is appropriate when subsequent final APLs are issued.

Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified laws, regulatory guidance, contracts, business practices and benefits. CalOptima has an annual policy review process by which Policies and Procedures are updated and implemented to comply with new laws, regulations, guidelines or programs as required. The following current Policies and Procedures have been impacted and staff is recommending approval of proposed updates:

1. ***FF.1002: CalOptima Medi-Cal Fee Schedule*** outlines the process by which CalOptima establishes and maintains the CalOptima Medi-Cal Fee Schedule for covered services for which CalOptima is financially responsible, in accordance with the DOFR. CalOptima staff proposes revisions to the policy pursuant to the CalOptima annual review process to address DHCS FFS reimbursement rates based on prospective and retroactive rate revisions as referenced in the published DHCS APLs, Medi-Cal Bulletins and NewsFlash when DHCS provides sufficient information to implement the rate revisions, including the effective date, reimbursement rate, current procedural terminology, CPT codes and any modifiers, as necessary. CalOptima shall implement FFS reimbursement rates received via published DHCS APLs, Medi-Cal Bulletins and NewsFlash to the extent the FFS reimbursement rate is not reflected in the Medi-Cal Fee Schedule. Proposed revisions also include basing DHCS FFS reimbursement rates on expected rates referenced in the pending State Plan Amendment filed with CMS for Proposition 56 directed payments if instructed in writing by DHCS and removing Operating Instruction Letters as a source for rate changes. Additional proposed changes are intended to include contracted providers' right to file a complaint, as well as updating definitions and several grammatical changes.

2. ***FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group*** outlines CalOptima's payment methodologies for a provider or practitioner that provides covered services to a member of CalOptima Direct or a member enrolled in a shared risk group. For those members enrolled in a shared risk group, The policy only applies to covered services for which CalOptima is financially responsible, in accordance with the DOFR. Revisions to the policy are being proposed pursuant to the CalOptima annual review process to address directed payments under policy FF.2012, licensed midwives services, and reimbursement for a 12-month supply of FDA-approved, self-administered hormonal contraceptives under specified circumstances. Proposed revisions also include the addition of language requiring a health network that authorizes an inpatient admission to retain financial responsibility for the entire stay notwithstanding a member's change in health network. Additional proposed updates include adding and updating definitions, as well as minor grammatical changes.

Fiscal Impact

The recommended action to approve CalOptima Policy FF.2012 and implement the other recommended change 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 program. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

The recommended action to revise CalOptima Policies FF.1002 and FF.1003 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget pending Board approval.

Rationale for Recommendation

The recommended action will ensure that CalOptima continues to be compliant with regulatory guidance provided by DHCS.

Concurrence

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

Attachments

1. Entities Covered by this Recommended Board Action
2. FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services
3. FF.1002: CalOptima Medi-Cal Fee Schedule
4. FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
5. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
6. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
7. 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/ Richard Sanchez — *05/27/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates	10855 Business Center Dr Ste. C	Cypress	CA	90630
Talbert Medical Group	2175 Park Place	El Segundo	CA	90245
Arta Western Medical Group	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
Alta Med Health Services Shared Risk	2040 Camfield Ave	Los Angeles	CA	90040

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Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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3. The Designated Provider was eligible to receive the Directed Payment.

4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A 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 GEMT Services.

E. CalOptima shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

F. CalOptima shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. For CalOptima Direct, how to file a grievance and second level appeal with CalOptima. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima.

H. CalOptima Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint and/or FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, as applicable.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), 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, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers 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:

            a) On or before the first birthday;

            b) After the first birthday and before or on the second birthday; or

            c) 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. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

    d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

        i. The tool that was used to perform the Developmental Screening Service;

        ii. That the completed screen was reviewed;

        iii. The interpretation of results;

        iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

        v. Any appropriate actions taken.

    e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

      ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

      iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

   b. CalOptima shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

      i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

      ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

   c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

      i. The tool that was used to perform the ACEs Screening Service;

      ii. That the completed screen was reviewed;

      iii. The interpretation of results;

      iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

      v. Any appropriate actions taken.

   d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2017, CalOptima shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

5. GEMT Services: For dates of service on or after July 1, 2018, CalOptima shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. CalOptima shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

b. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by CalOptima with specified dates of service (i.e., between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), CalOptima shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, CalOptima shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by CalOptima no later than one (1) year from the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima shall:

    a. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

    b. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Provider, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

1. CalOptima shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Policy FF.2011: Directed Payments, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by DHCS, including an attestation confirming the completion of the report. Reports shall include CalOptima's Health Care Plan Code, as well as CPT, HCPCS, or Procedure Code, service

month, payer (e.g., CalOptima or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

a. CalOptima shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima must submit an attestation to DHCS stating that no updated information is available.

b. If updated information is available for the quarterly report, CalOptima must submit the updated quarterly report in the appropriate file format and include an attestation that CalOptima considers the report complete.

2. CalOptima shall continue to submit encounter data for the Directed Payments as required by DHCS.

IV. ATTACHMENTS

A. Directed Payments Rates and Codes

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Medi-Cal Glossary of Terms
C. 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 FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
G. CalOptima Policy FF.2003: Coordination of Benefits
H. CalOptima Policy FF.2011: Directed Payments
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1116: Pediatric Preventive Services
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
M. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
N. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
P. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
T. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
U. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services

V. 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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective				

IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Centers for Medicaid and Medicare Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
Centers for Medicaid and Medicare Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare and Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.

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 notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
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.

Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
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	For purposes of this Policy, specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to CalOptima Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, 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
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

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Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

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[3]	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).

[3]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.

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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[4]
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

[4]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.

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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[6]	
		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

[6]*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.

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Policy: FF.1002
Title: **CalOptima Medi-Cal Fee Schedule**
Department: Coding Initiatives
Section: Not Applicable

CEO Approval:

Effective Date: 10/01/2006
Revised Date: TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima shall establish and maintain the CalOptima Medi-Cal Fee Schedule.

II. POLICY

A. CalOptima shall maintain a Medi-Cal Fee Schedule to determine payments to Providers and Practitioners, as applicable.

III. PROCEDURE

A. The Department of Health Care Services (DHCS) provides a complete file of the Medi-Cal Fee-for-Service (FFS) Fee Schedule to the public on a monthly basis.

B. Effective April 1, 2011, CalOptima shall update the CalOptima Medi-Cal Fee Schedule on a monthly basis based on the monthly file released by DHCS used to update the Medi-Cal Fee-for-Service (FFS) Fee Schedule.

1. Monthly updates to the CalOptima Medi-Cal Fee Schedule shall be effective the first day of the month following CalOptima's receipt of the monthly file released by DHCS.

C. DHCS provides rates for Child Health and Disability Prevention (CHDP) services and medical and incontinence supplies to the public through the Medi-Cal Provider Manuals. DHCS updates the manuals based on subsequent rate changes.

~~2.~~1. For dates of service on or after July 1, 2018, rates for CHDP will be included in the Medi-Cal Fee-for-Service (FFS) Fee Schedule rather than in the Provider Manuals.

~~C.~~D. The CalOptima Medi-Cal Fee Schedule is based on the following:

1. DHCS FFS reimbursement rates as included in the Medi-Cal Fee-for-Service (FFS) Fee Schedule;

2. DHCS FFS reimbursement rates as referenced in the Medi-Cal Provider Manual for medical and incontinence supplies; and

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3. DHCS FFS reimbursement rates based on prospective and retroactive rate revisions ~~issued by~~as referenced in the published DHCS ~~through Operating Instruction~~ All Plan Letters ~~(OILs).~~, Medi-Cal Bulletins and NewsFlash when DHCS provides sufficient information to implement the rate revisions, including the effective date, reimbursement rate, healthcare common procedure coding system (HCPCS) codes, current procedural terminology (CPT) codes and any modifiers, as necessary. CalOptima shall implement FFS reimbursement rates received via ~~OILs~~published DHCS All Plan Letters, Medi-Cal Bulletins and NewsFlash to the extent the FFS reimbursement rate is not reflected in the Medi-Cal Fee Schedule~~, unless such OIL is related to a~~; and

~~3.~~4. DHCS FFS reimbursement rates are based on expected rates as referenced in the pending State Plan Amendment ~~(SPA) not approved by~~ filed with the Centers for Medicare & Medicaid Services (CMS~~).~~) for Proposition 56 directed payments if instructed, in writing, by DHCS. In the event the expected rates are not approved by CMS, CalOptima shall recoup overpayments and refund underpayments, as applicable, in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

~~D.~~E. CalOptima shall reimburse Providers and Practitioners for Covered Services provided to CalOptima Direct members based on the CalOptima Medi-Cal Fee Schedule in effect on the date the claim is processed for date(s) of service submitted, unless otherwise required by law or contract in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

1. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a non-contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable.

2. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable, as required by law or contract.

~~1.~~3. ~~A non-contracted~~A Provider or Practitioner, whether contracted or non-contracted, shall have the right to file a complaint in accordance with CalOptima Policies 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, and HH.1101: CalOptima Provider Complaint.~~.~~

~~2.1. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable, as required by law or contract.~~

~~E.~~F. CalOptima may, in its sole discretion, update the CalOptima Medi-Cal Fee Schedule between the regularly scheduled updates.

~~F.~~G. A Provider and Practitioner shall submit claims for Covered Services rendered to a CalOptima Direct member 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.

~~G.~~H. The Medi-Cal Fee-for-Service (FFS) Fee Schedule and Provider Manuals are available by accessing the Medi-Cal website.

IV. ATACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Medi-Cal Fee-For-Service Rates: ~~https://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp~~ https://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp
~~G. Medi-Cal Provider Manual: Publications; Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp~~
G. Medi-Cal Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

VI. REGULATORY AGENCY APROVAL(S)

Date	Regulatory Agency
03/14/2011	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2006	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2011	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2016	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/01/2017	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/07/2018	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	05/01/2019	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	TBD	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Covered Service	For purposes of this policy, 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), 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 single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Fee-For-Service Amounts	Amounts adopted by CalOptima for reimbursement to hospitals, physicians and other providers for medical services rendered (other than on a capitated payment basis) to Medi-Cal beneficiaries for which CalOptima is responsible.
Medi-Cal Fee-For-Service (FFS) Fee Schedule	The fee schedule used by the Department of Health Care Services (DHCS) to reimburse Medi-Cal Fee-For-Service Providers.

Term	Definition
Medi-Cal Provider Manual	A provider manual created and updated by the Department of Health Care Services as a reference for providers enrolled in the Medi-Cal Fee-for-Service program to include information on Medi-Cal services, programs, claim reimbursement, complete information about recipient eligibility and provider participation, program policies, code lists, claim form and follow-up instructions pertaining to specific provider communities and specialty programs.
~~Operating Instruction Letter~~	~~A letter issued by the Department of Health Care Service to its Fiscal Intermediary for purposes of administering the Medi-Cal Fee-For-Service program.~~
Overpayment	For the purposes of this policy, 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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	~~A~~ All contracted Providers including physicians, Non-physician~~, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory~~ Medical Practitioners, ancillary ~~provider, health maintenance organization,~~providers, and facilities or ~~other person or institution that furnishes~~institutions who are licensed to furnish Covered Services.

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Policy: FF.1002
Title: **CalOptima Medi-Cal Fee Schedule**
Department: Coding Initiatives
Section: Not Applicable

CEO Approval:

Effective Date: 10/01/2006
Revised Date: TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima shall establish and maintain the CalOptima Medi-Cal Fee Schedule.

II. POLICY

A. CalOptima shall maintain a Medi-Cal Fee Schedule to determine payments to Providers and Practitioners, as applicable.

III. PROCEDURE

A. The Department of Health Care Services (DHCS) provides a complete file of the Medi-Cal Fee-for-Service (FFS) Fee Schedule to the public on a monthly basis.

B. Effective April 1, 2011, CalOptima shall update the CalOptima Medi-Cal Fee Schedule on a monthly basis based on the monthly file released by DHCS used to update the Medi-Cal Fee-for-Service (FFS) Fee Schedule.

1. Monthly updates to the CalOptima Medi-Cal Fee Schedule shall be effective the first day of the month following CalOptima's receipt of the monthly file released by DHCS.

C. DHCS provides rates for Child Health and Disability Prevention (CHDP) services and medical and incontinence supplies to the public through the Medi-Cal Provider Manuals. DHCS updates the manuals based on subsequent rate changes.

1. For dates of service on or after July 1, 2018, rates for CHDP will be included in the Medi-Cal Fee-for-Service (FFS) Fee Schedule rather than in the Provider Manuals.

D. The CalOptima Medi-Cal Fee Schedule is based on the following:

1. DHCS FFS reimbursement rates as included in the Medi-Cal Fee-for-Service (FFS) Fee Schedule;

2. DHCS FFS reimbursement rates as referenced in the Medi-Cal Provider Manual for medical and incontinence supplies; and

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3. DHCS FFS reimbursement rates based on prospective and retroactive rate revisions as referenced in the published DHCS All Plan Letters, Medi-Cal Bulletins and NewsFlash when DHCS provides sufficient information to implement the rate revisions, including the effective date, reimbursement rate, healthcare common procedure coding system (HCPCS) codes, current procedural terminology (CPT) codes and any modifiers, as necessary. CalOptima shall implement FFS reimbursement rates received via published DHCS All Plan Letters, Medi-Cal Bulletins and NewsFlash to the extent the FFS reimbursement rate is not reflected in the Medi-Cal Fee Schedule; and

4. DHCS FFS reimbursement rates are based on expected rates as referenced in the pending State Plan Amendment filed with the Centers for Medicare & Medicaid Services (CMS) for Proposition 56 directed payments if instructed, in writing, by DHCS. In the event the expected rates are not approved by CMS, CalOptima shall recoup overpayments and refund underpayments, as applicable, in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

E. CalOptima shall reimburse Providers and Practitioners for Covered Services provided to CalOptima Direct members based on the CalOptima Medi-Cal Fee Schedule in effect on the date the claim is processed for date(s) of service submitted, unless otherwise required by law or contract in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

1. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a non-contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable.

2. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable, as required by law or contract.

3. A Provider or Practitioner, whether contracted or non-contracted, shall have the right to file a complaint in accordance with CalOptima Policies 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, and HH.1101: CalOptima Provider Complaint.

F. CalOptima may, in its sole discretion, update the CalOptima Medi-Cal Fee Schedule between the regularly scheduled updates.

G. A Provider and Practitioner shall submit claims for Covered Services rendered to a CalOptima Direct member 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.

H. The Medi-Cal Fee-for-Service (FFS) Fee Schedule and Provider Manuals are available by accessing the Medi-Cal website.

IV. ATACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Medi-Cal Fee-For-Service Rates: https://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp
G. Medi-Cal Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

VI. REGULATORY AGENCY APROVAL(S)

Date	Regulatory Agency
03/14/2011	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2006	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2011	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2016	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/01/2017	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/07/2018	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	05/01/2019	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	TBD	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Covered Service	For purposes of this policy, 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.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Fee-For-Service Amounts	Amounts adopted by CalOptima for reimbursement to hospitals, physicians and other providers for medical services rendered (other than on a capitated payment basis) to Medi-Cal beneficiaries for which CalOptima is responsible.
Medi-Cal Fee-For-Service (FFS) Fee Schedule	The fee schedule used by the Department of Health Care Services (DHCS) to reimburse Medi-Cal Fee-For-Service Providers.

Term	Definition
Medi-Cal Provider Manual	A provider manual created and updated by the Department of Health Care Services as a reference for providers enrolled in the Medi-Cal Fee-for-Service program to include information on Medi-Cal services, programs, claim reimbursement, complete information about recipient eligibility and provider participation, program policies, code lists, claim form and follow-up instructions pertaining to specific provider communities and specialty programs.
Overpayment	For the purposes of this policy, 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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who are licensed to furnish Covered Services.

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Policy:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/07
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a ~~Non-Contracted Hospital~~non-contracted hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, ~~shall be~~ in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's ~~prior authorization~~Prior Authorization policies, ~~shall be based on the following~~is as follows:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section

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14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior ~~authorization~~Authorization is required for all non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

e. Border Hospitals: ~~For dates of service after July 1, 2015,~~ CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

4. If a Member changes Health Networks, including CalOptima Direct, for purposes of this provision, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member ~~of CalOptima Direct or a Member enrolled in a Shared Risk Group,~~ as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-~~Contracted~~contracted Practitioner: CalOptima's reimbursement to a ~~Non-Contracted~~non-contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

   a. Emergency Services: CalOptima shall reimburse a ~~Non-Contracted~~non-contracted Practitioner that provides ~~Emergency~~emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

   b. Non-Emergency Services: CalOptima shall reimburse a ~~Non-Contracted~~non-contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

      i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program. ~~.~~

      ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program ~~-~~paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

      iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse ~~up thirteen cycles of oral contraceptives,~~ a ~~twelve~~ provider, including a non-contracted provider, for a (12~~))~~-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches ~~(36 patches), and a twelve (12) month supply of~~, or hormone-containing contraceptive vaginal rings ~~(12 rings), if such quantity is~~when dispensed ~~in an onsite clinic and billed~~at one time at a Member's request by a ~~Qualified Family Planning Provider, including a non-contracted Qualified Family Planning Provider, or dispensed by a~~qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife ~~or Certified Nurse Practitioner services~~and licensed midwives services as permitted within each practitioner's scope of practice, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

i. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

   a. If the American Indian Health Service Program is a Rrural Hhealth Cclinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

   b. If the American Indian Health Service Program is a Rrural Hhealth Cclinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

   c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register-. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

   a. The American Indian Health Service Program provider must be identified by DHCS;

   b. Service must be a Covered Service included in CalOptima's contract with DHCS;

   c. As set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

      i. Medical health visit;

      ii. Mental health visit;

      iii. Ambulatory visit.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an ~~Ancillary Service~~ancillary service Provider for Covered Services rendered to a

Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted ~~Ancillary Services Provider~~ancillary service provider based on the terms and conditions of the contract between such ~~Contracted Ancillary Service Provider~~contracted ancillary service provider and CalOptima.

2. CalOptima shall reimburse a ~~Non-Contracted Ancillary Services Provider~~non-contracted ancillary service provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Directed Payment: CalOptima shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for which CalOptima is financially responsible, in accordance with the requirements of CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to a Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services.

~~G.~~H. Non-~~Contracted Hospitals, Non-Contracted~~contracted hospitals, non-contracted Practitioners, and ~~Non-Contracted Ancillary Service~~non-contracted ancillary service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

~~H.~~I. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

~~I.~~J. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B. CalOptima Policy AA.1000: Glossary of Terms~~
~~C.~~B. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
C. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group

D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.2011: Directed Payments
F. CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services
G. CalOptima Policy GG.1116: Pediatric Preventive Services
~~F. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group~~
~~G.~~H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~H.F. CalOptima Policy GG.1116: Pediatric Preventive Services~~
I. CalOptima Policy HH.2022Δ: Record Retention and Access
J. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
K. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
L. ~~Section 1932(b)(2)(D)~~Title 42 of the Code of Federal Regulations, § 422.113(c)(3)
~~L.~~M. Social Security Act, Section 1932(b)(2)(D)
~~M.~~N. California Welfare and Institutions Code~~,§§, ~~, §14105.28 ~~and 14166.245~~
~~N.~~O. California Health and Safety Code, §1797.1
~~O. This policy supersedes:~~
~~P. CalOptima Financial Letter dated August 25, 1995: Fee for service rates~~
~~Q. CalOptima Financial Bulletin #3: Inpatient hospital reimbursement rates under "CalOptima Direct"~~
~~R. CalOptima Financial Bulletin #5: Revised "CalOptima Direct" inpatient hospital rates~~
~~S. CalOptima Financial Bulletin #10: Family planning services~~
~~T. CalOptima Financial Bulletin #17: Additions to CalOptima Direct inpatient hospital rates~~
~~U. CalOptima Financial Bulletin #19: CalOptima Direct rates effective October 1, 1999~~
~~V. CalOptima Financial Bulletin #24: CalOptima Direct rates effective July 1, 2002~~
~~W. CalOptima Financial Bulletin #29: CalOptima Direct rates effective March 1, 2004~~
~~X.~~P. Manual of Current Procedural Terminology (CPT®), American Medical Association~~, Revised 2006~~
~~Y.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
~~Z.~~R. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: ~~-~~Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
~~AA.~~S. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: ~~-~~Hospital Payment for Medi-Cal Post-Stabilization Services
~~BB.~~T. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: ~~-~~Sexually Transmitted Disease Services in Medi-Cal Managed Care
~~CC.~~U. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: ~~-~~Rates ~~For~~for Emergency and Post-Stabilization Acute Inpatient Services Provided ~~By~~by Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
~~DD.~~V. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~16-003(*revised*):~~18-019: Family Planning Services Policy for ~~Contraceptive Supplies~~Self-Administered Hormonal Contraceptives
~~EE.~~W. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~15-017:~~ 18-022: Access Requirements for Freestanding Birth Centers and the Provision of ~~Certified Nurse~~ Midwife ~~and Alternative Birth Center Facility~~ Services ~~(Revised)~~
~~FF.~~X. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~16-016~~19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network ~~"~~Border~~"~~ Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
12/10/2009	Department of Health Care Services (DHCS)
03/10/2014	Department of Health Care Services (DHCS)
07/06/2016	Department of Health Care Services (DHCS)
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/04/2002	Regular Meeting of the CalOptima Board of Directors
06/05/2007	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
06/03/2008	Regular Meeting of the CalOptima Board of Directors
10/02/2008	Regular Meeting of the CalOptima Board of Directors
11/06/2008	Regular Meeting of the CalOptima Board of Directors
11/05/2009	Regular Meeting of the CalOptima Board of Directors
06/06/2013	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/06/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	TBD	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

IX. GLOSSARY

Term	Definition
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.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, ~~California Code of Regulations (~~CCR~~),~~ Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), 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 identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

Term	Definition
Federally Qualified Health Center	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
~~American Indian Health Services Program~~Medically Necessary or Medical Necessity	~~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.~~ 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).
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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Licensed Midwife, Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.

Term	Definition
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200. ~~A Physician, Physician Assistant (under the supervision of a Physician), Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medications. Pursuant to California Business and Professions Code section 2725.2, if these contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to Business and Professions Code section 2725.2 and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier TD (TD modifier as used for RN for (Behavioral Health) as found in the Medi-Cal Provider Manual.~~
Rural Health Clinic	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Policy:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/07
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a non-contracted hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's Prior Authorization policies, is as follows:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

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b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior Authorization is required for all non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

e. Border Hospitals: CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

4. If a Member changes Health Networks, including CalOptima Direct, for purposes of this provision, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-contracted Practitioner: CalOptima's reimbursement to a non-contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

   a. Emergency Services: CalOptima shall reimburse a non-contracted Practitioner that provides emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

   b. Non-Emergency Services: CalOptima shall reimburse a non-contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

      i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program-paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

      iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

      viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by

DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse a provider, including a non-contracted provider, for a (12)-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a Member's request by a qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife and licensed midwives services as permitted within each practitioner's scope of practice, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

i. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

a. The American Indian Health Service Program provider must be identified by DHCS;

b. Service must be a Covered Service included in CalOptima's contract with DHCS;

c. As set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

i. Medical health visit;

ii. Mental health visit;

iii. Ambulatory visit.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an ancillary service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted ancillary service provider based on the terms and conditions of the contract between such contracted ancillary service provider and CalOptima.

2. CalOptima shall reimburse a non-contracted ancillary service provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Directed Payment: CalOptima shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for which CalOptima is financially responsible, in accordance with the requirements of CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to a Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services.

H. Non-contracted hospitals, non-contracted Practitioners, and non-contracted ancillary service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

I. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

J. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
C. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.2011: Directed Payments
F. CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services
G. CalOptima Policy GG.1116: Pediatric Preventive Services
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy HH.2022Δ: Record Retention and Access

J. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
K. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
L. Title 42 of the Code of Federal Regulations, § 422.113(c)(3)
M. Social Security Act, Section 1932(b)(2)(D)
N. California Welfare and Institutions Code, §14105.28
O. California Health and Safety Code, §1797.1
P. Manual of Current Procedural Terminology (CPT®), American Medical Association
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
T. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
U. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-019: Family Planning Services Policy for Self-Administered Hormonal Contraceptives
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services
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Date	Regulatory Agency
12/10/2009	Department of Health Care Services (DHCS)
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VII. BOARD ACTION(S)

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	TBD	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

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IX. GLOSSARY

Term	Definition
American Indian Health Services Program	Programs operated 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.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (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.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

Term	Definition
Federally Qualified Health Center	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Licensed Midwife, Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200.
Rural Health Clinic	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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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**

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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

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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**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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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**

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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

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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**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

8. Consider Authorization of the Reallocation of Budgeted but Unspent Salary Dollars to Expand the Scope of Work of a Contract for External Peer Review Services Contract and Extend a Contract for Medical Consulting Services

Contacts

David Ramirez, M.D., Chief Medical Officer, Medical Management, (714) 347-3261
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574
Esther Okajima, Director, Quality Improvement, (714)347-3270

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with Advanced Medical Reviews (AMR) to expand the scope of work to include the provision of the following services:
    a. Retro claims review to ensure medical services are billed appropriately;
    b. Review of Grievance and Appeal cases to ensure same or similar specialty review;
    c. Review of Behavioral Health cases; and
    d. Review of Fraud, Waste and Abuse cases.
2. Authorize reallocation of budgeted but unused funds to support the expanded scope of services for AMR through June 30, 2021:
    a. Up to $28,000 from Medical Management – Salaries to Medical Management – Professional Fees; and
    b. Up to $52,000 from Medical Management – Salaries to Administrative Expenses – Professional Fees; and
3. Authorize reallocation of budgeted but unused funds of up to $45,000 from Medical Management – Salaries to Medi-Cal Management – Professional Fees and to extend the contract with medical consultant, Peter Scheid, M.D., to assist with Potential Quality Issue (PQI) cases through June 30, 2021.

Background

CalOptima is required to review appeals and potential quality issues in order to maintain compliance with existing regulations and contractual obligations. Additionally, CalOptima must complete reviews within required timeframes in order to maintain compliance. Each month, CalOptima completes on average 140 appeal reviews and 134 PQI reviews. CalOptima currently has a staff of 6 board certified Medical Directors and two Medical Director positions that have been open since June 2018 and January 2019, respectively. CalOptima Medical Directors share 24/7 call coverage and also assist with committee meetings, clinical programs and projects, and quality improvement efforts.

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Since 2012, with CalOptima's pursuit of accreditation, use of board-certified consultants to assist in making medical necessity determinations is a requirement per National Committee for Quality Assurance (NCQA) Utilization Management (UM) Standards. Also, in the case of appeals, the review of an appeal must be conducted with a practitioner who is in the same or similar specialty. Per these standards, CalOptima must have policies and procedures for how board-certified consultants are used and provide evidence of how they are used as part of the decision-making process for denials and appeals.

On February 1, 2014, CalOptima entered into a contract with Advanced Medical Reviews (AMR). Currently, AMR is the only outside entity that provides clinical medical record review services for CalOptima.

With regard to hiring medical consultants, on April 2, 2020, the Board of Directors (the Board) approved reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants to assist with CalOptima's response to the Coronavirus (COVID-19) pandemic (refer to Attachment 1). On April 16, 2020, the Board authorized amendments to contracts with medical consultants and authorized unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020 (refer to Attachment 2). In order to maintain compliance with the required reviews of appeals and PQIs, staff is requesting reallocation of funding from the open Medical Director positions to support continued use of the temporary consultant.

Discussion

External Peer Review

There are many benefits for using External Peer Reviews (EPRs) for clinical medical record review. It can address conflicts of interest by removing bias and assists with regulatory, credentialing and accreditation requirements. Independent review services can also remove barriers for quality improvement efforts, ensure adherence to quality standards and reduce liability risk. Circumstances where a health plan would seek external peer review include, but are not limited to:

1. Litigation;
2. Conflicting recommendations from internal reviewers;
3. Lack of internal resources and expertise;
4. Review by same or similar specialty; and
5. Improving efficiency

Multiple CalOptima departments have business demands that require timely access to independent review services. Currently, Medical Directors leverage EPRs for the review of Potential Quality Issue (PQI) cases when the physician under review is of a specialty outside of the Medical Directors. CalOptima's current Medical Directors are board certified in Family Medicine, Internal Medicine, Psychiatry, Pediatrics and Cardiothoracic Surgery. Cases outside of these specialties are referred for independent review services. UM Medical Directors utilize EPRs to review denial cases as needed. Grievance and Appeals leverage independent review services to review second level appeals, especially when a reviewer with same or similar specialty is required. Claims utilizes EPRs for coding

validation of billed services. For Behavioral Health, only a qualified licensed clinical psychologist or board-certified psychiatrist can review and issue denials for medical necessity or benefit coverage. Access to EPRs with behavioral health specialty is essential in meeting regulatory requirements. Compliance utilizes EPRs to assist with reviewing medical records for potential Fraud, Waste and Abuse (FWA) cases. An effective Compliance Program requires timely investigation to ensure CalOptima can seek overpayment recovery or implement necessary preventive controls.

Management proposes to make a reallocation of budgeted but unused funds of $80,000 from Medical Management – Salaries. Several Medical Management vacant positions remain vacant, thereby making these funds available for reallocation.

- Reallocation of $28,000 from Medical Management – Salaries to Medical Management – Professional Fees: The CalOptima Fiscal Year (FY) 2020-21 Operating Budget includes $80,000 for external peer review services. With an expanded scope of services for AMR, staff projects a budget shortfall of $28,000 through June 30, 2021.

- Reallocation of $52,000 from Medical Management – Salaries to Administrative Expenses – Professional Fees. The forecasted budget shortfall is based on current retroactive claims review utilization with a 10% increase to allow for any unexpected increase in utilization (see Attachment 3 for more details)

Medical Consultant

CalOptima's Medical Management Department requires additional resources in clinical reviews to reduce the workload for the current Medical Directors, especially in PQI cases. Unfortunately, CalOptima staff have been encountering challenges with hiring new Medical Directors. While continuing the efforts to recruit new Medical Directors, in the interim, CalOptima staff recommends extending a contract with the medical consultant, Dr. Peter Scheid, who is familiar with CalOptima's quality standards and internal processes, to provide additional clinical support to ensure our members' quality of care during this difficult time.

Management proposes to make a reallocation of budgeted but unused funds of up to $45,000 from Medical Management – Salaries to Medi-Cal Management – Professional Fees to fund the contract through June 30, 2021.

Fiscal Impact

The fiscal impact for the recommended actions is budget neutral. Unspent budgeted funds from Medical Management – Salaries approved in the CalOptima Fiscal Year 2020-21 Operating Budget on June 4, 2020, will fund the total cost of $125,000 for the recommended actions.

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Rationale for Recommendation

Staff is recommending Board approval to reallocate funds to meet changing business needs and expand options for external peer review to ensure optimal efficiency and timeliness in the clinical medical record review process. Staff also believes that extending the contract with the medical consultant will help reviewing PQI cases and other clinical decisions in a timely manner while maintaining high quality standards.

Concurrence

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

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated April 2, 2020, "Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities"
3. Previous Board Action Dated April 16, 2020, "Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic"
4. AMR Consultants Usage Log

/s/ Richard Sanchez — *11/24/2020*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Advanced Medical Reviews	PO Box 492345	Redding	CA	96049
Peter J. Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

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Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

Back to Agenda Back to Item

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL.COM
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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020
Special Meeting of the CalOptima Board of Directors

Report Item
4. Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $80,327; and

2. Authorize amendments to contracts with medical consultants Tanya Dansky, M.D. and Peter Scheid, M.D., who are assisting with CalOptima's response to the coronavirus pandemic, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the Board ratified unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed $915,000. Under a separate action, the Board also ratified contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., to assist with CalOptima's response to the coronavirus situation, and reallocated budgeted but unused funds of $20,000 from the Professional Fees budget to fund these contracts.

Discussion
Emergency Purchases Related to Coronavirus Pandemic
Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	$30,110
	Member personal protective equipment	$4,734
Information Services	Remote printing, mailing for operational areas (i.e., UM, Claims, MLTSS, GARs)	$30,000
Facilities	Staff personal protective equipment	$11,905
	Gloves, disinfectant products	$578

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Department	Description	Amount
	Estimated expenses for disinfectant products through June 30, 2020 ($1,000/month)	$3,000
	Total	**$80,327**

CalOptima contracted with the existing vendors to ensure timely and efficient service, compatibility with existing equipment, and the protection and security of CalOptima's employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Contract Extensions with Medical Consultants

Staff recommends extending contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., through June 30, 2020, in order to continue work related to coronavirus mitigation activities, including information review and dissemination, regulatory reporting, collaboration with state, county and local entities, and other support activities for the Chief Medical Officer, as needed. The additional cost for the contract extensions through June 30, 2020, is $48,000.

Fiscal Impact

The recommended actions to ratify and authorize unbudgeted expenditures related to coronavirus pandemic and extend contracts with medical consultants are unbudgeted items. An allocation of up to $128,327 from existing reserves will fund these actions.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

/s/ Richard Sanchez — *04/10/2020*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Tanya Dansky, M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

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Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

Back to Agenda Back to Item

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL.COM
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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

AMR Consultants	FY19-20	FY20-21	14 mo RR	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
Claims	$ 53,781	$ 5,319	$ 4,221		$ 1,379	$ 3,152	$ 4,531	$ 2,758	$ 6,501	$ 5,319	$ 5,319	$ 7,683	$ 5,713	$ 7,683	$ 3,743	$ 1,182	$ 4,137										
FWA	$ 8,393	$ 1,169	$ 683									$ 3,087	$ 775	$ 3,546	$ 985	$ 197	$ 972										
GARS	$ 54,372	$ 20,685	$ 5,361	$ 3,940	$ 2,561	$ 4,728	$ 6,304	$ 2,955	$ 7,880	$ 1,970	$ 6,698	$ 3,349	$ 5,122		$ 8,865	$ 9,850	$ 10,835										
Pharmacy	$ 1,773	$ -	$ 127	$ 197						$ 197		$ 197	$ 197		$ 985												
PQI	$ 7,513	$ 1,182	$ 621	$ 394	$ 486	$ 381	$ 1,773	$ 1,366	$ 486	$ 788	$ 1,445	$ 197			$ 197	$ 394	$ 788										
UM	$ 16,115	$ 5,132	$ 1,518	$ 92	$ 394	$ 197	$ 985	$ 985	$ 3,349	$ 3,546	$ 473	$ 1,366	$ 1,576	$ 1,379	$ 1,773	$ 3,047	$ 2,085										
Total	**$ 141,947**	**$ 33,487**	$ 12,531	**$ 4,623**	**$ 4,820**	**$ 8,458**	**$ 13,593**	**$ 8,064**	**$ 18,216**	**$ 11,820**	**$ 13,935**	**$ 15,879**	**$ 13,383**	**$ 12,608**	**$ 16,548**	**$ 14,670**	**$ 18,817**										

Medical Consultant Services	FY19-20	FY20-21	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
Tanya Dansky, MD	$ 10,500	$ -										$ 5,250	$ 5,250													
Peter Scheid, MD	$ 20,700	$ 10,050									$ 4,200	$ 4,200	$ 4,800	$ 7,500	$ 4,950	$ 5,100										
Total	**$ 31,200**	**$ 10,050**									**$ 4,200**	**$ 9,450**	**$ 10,050**	**$ 7,500**	**$ 4,950**	**$ 5,100**										

Budget	**Monthly Est'**
818-020 Budget	$ 6,667
Medical Directory Salary .5 FTE	$ 9,265
Total	$ 15,931
Run Rate 2020 CY	**Monthly Est'**
AMR with Claims/GARS:	$ 14,708
AMR with GARS, no Claims:	$ 9,610
AMR without Claims/GARS:	$ 3,774
Medical Consultant 10hr/Wk*$300/hr	$ 13,500

Existing Budget 818-020	80000
Run Rate * 10 months	125310
July/August invoice	34000
Claims Fund Request	52000
Amt needed in 818-020	27310

Row Labels	Count of Referring Dept
2019	**436**
Claims	106
GARS	216
Pharmacy	5
PQI	62
UM	47
2020	**480**
Claims	195
FWA	31
GARS	168
Pharmacy	8
PQI	16
UM	62
Grand Total	**916**

Row Labels	Count of Refer	Sum of Amount Billed
2019	**421**	**$ 64,669.00**
Claims	106	$ 20,882.00
GARS	213	$ 31,126.00
Pharmacy	5	$ 394.00
PQI	56	$ 5,477.00
UM	41	$ 6,790.00
2020	**487**	**$ 93,524.00**
Claims	195	$ 38,415.00
FWA	31	$ 4,847.00
GARS	173	$ 34,081.00
Pharmacy	8	$ 1,576.00
PQI	16	$ 2,627.00
UM	64	$ 11,978.00
Grand Total	**908**	**$ 158,193.00**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

9. Consider Approval of Actions Authorizing Extensions and Other Modifications of Whole Person Care Agreements with the Orange County Health Care Agency

Contacts

Ladan Khamseh, Chief Executive Officer, (714) 246-8866
Candice Gomez, Executive Director Program Implementation, (714) 246-8849
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Recommend, contingent on extension of the Whole Person Care (WPC) pilot in the Medi-Cal 2020 Waiver, authorizing the Chief Executive Officer, with assistance of legal counsel, to extend and amend the following agreements with the Orange County Health Care Agency (OCHCA) consistent with the WPC extension(s) granted:

1. WPC Administrative Services Agreement; and
2. WPC Grant Agreement for Recuperative Care Services

Background

On October 24, 2016 the County of Orange (County) received approval from the Department of Health Care Services (DHCS) for a five-year program to implement the WPC. Administered by the OCHCA, WPC takes a patient-centered approach to coordinate physical, behavioral health, and social services with the overall goal to improve the health and well-being of Medi-Cal members experiencing homelessness. Recuperative Care is a key service provided under the County's WPC pilot, providing supportive care following discharge from an emergency room, inpatient hospitalization, or skilled nursing facility to Medi-Cal beneficiaries experiencing homelessness and meeting criteria. Recuperative care is also initiated based on direct referrals from clinics, public health nurses, and outreach and engagement staff.

The current WPC is set to expire on December 31, 2020. DHCS has requested CMS approval of a one year extension of the Medi-Cal 2020 wavier, including WPC pilots, through December 31, 2021; this includes a request for additional funding for WPC. While it is expected that the WPC will continue, final determination on the extension and, if approved, any details may not be known by the end of the year. WPC may be extended on a month-to-month basis until final determination is made. Should the federal extension not be granted, OCHCA will be able to support ongoing administration and wind-down of WPC, including recuperative care, until April 1, 2021.

CalOptima has participated in the WPC since its inception and has executed two separate agreements with OCHCA for administrative services and a recuperative care grant. Both agreements currently expire on December 31, 2020.

Administrative Services Agreement

On June 1, 2017 the Board approved an Administrative Services agreement with OCHCA for participation in the pilot. Pursuant to the DHCS-approved budget and Administrative Services

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Agreement, CalOptima received $100,000 per pilot year towards:

- Administrative support:
  - Physical space for meetings, as well as information systems and project management support for the workgroups;
  - Baseline data to facilitate goal setting and program development; and
  - Data sharing about beneficiaries for better coordination of care, subject to applicable privacy laws, as well as HEDIS data to demonstrate improved outcomes for homeless such as decreased ED visits and hospitalization, as well as increased utilization for prescription, professional and preventative services.
- Coordination support:
  - A WPC Personal Care Coordinator (PCC) to help homeless WPC beneficiaries and organizations supporting them, to navigate CalOptima, health networks and provider.

CalOptima staff time for the project management, data sharing, PCC support and other WPC related activities are allocated against the $100,000 annual payment based on employee related costs accounts in the fiscal year in which it is received. The final $100,000 annual payment was received in August 2020 and allocated towards fiscal year 2020-21.

Recuperative Care Grant Agreement

In 2015, CalOptima implemented a recuperative care pilot using Intergovernmental Funds Transfers (IGT) funds. In total, $1 million from IGT 2 and IGT 3 was allocated towards recuperative care that was initially provided by participating contracted hospitals. On September 7, 2017, the Board authorized CalOptima to end its recuperative care hospital agreements and redirect the remaining IGT funds to OCHCA's WPC recuperative care program. Reimbursement for recuperative care was provided with a cap of $150 per day for up to 15 days following a referral from an emergency room or inpatient discharge.

On August 2, 2018, the Board approved an additional grant of $10 million from IGT 6 and 7, subject to availability of IGT funds. Along with the additional funding, the Board removed the daily funding cap and authorized a 50/50 cost split between the County and CalOptima for up to 90 days. Subsequently, in separate Board actions on December 5, 2019 and June 4, 2020, $2.75 million of the original $10 million CalOptima grant was reallocated towards medical respite ($250,000) and housing supportive services ($2.5 million). Remaining CalOptima grant funding was initially expected to be exhausted concurrent with implementation of recuperative care services as a covered Medi-Cal in-lieu of service benefit on January 1, 2021, as proposed under the state's CalAIM initiative. That initiative, however, has been postponed indefinitely due to the COVID-19 pandemic.

The $2.5 million initially allocated for housing supportive services was reallocated for the Homekey Program by the Board at the request of the County on November 5, 2020. Approximately $3 million of the total $7.25 million of recuperative care allocation has been paid for services through December 2019. The County has advised CalOptima that approximately $1.5 million was accrued through June 2020 and, as of October 15, 2020 remains unbilled. Based on current recuperative care utilization, funding may be adequate to continue until July 2021. However, if the allocated CalOptima funding became the sole funding source, it could be exhausted by April 2021. Because the agreement between CalOptima and the County automatically terminates if the agreement between the County and DHCS for the WPC pilot ends, CalOptima and the County would have to enter into a new contract for the IGT

funds to continue to be used for recuperative care administered by the County if the Whole Person Care pilot is not extended beyond December 31, 2020.

Discussion

The current WPC is set to expire on December 31, 2020. DHCS has requested federal approval for a 1-year extension of the WPC pilots, through December 31, 2021. This includes a request for additional funding for WPC. Final determination on the extension and, if approved, any details regarding funding may not be known by the end of the year. Additionally, while the OCHCA has indicated an interest in continued participation, it is unknown whether local match funding will be available to support continued participation in the WPC pilot after December 31, 2020. Consequently, OCHCA has advised that funding after December 31, 2020 is not expected to be at the same level and expects to focus on critical components of the pilot, which include housing navigation and sustainability services, recuperative care, and the WPC Connect data sharing platform.

OCHCA and CalOptima staff have discussed potential extension and modifications of the administrative services and recuperative care grant agreements to address contingencies including WPC termination at the end 2020, extension through 2021 and operational modifications. As a result, CalOptima staff recommends the following modifications to the current agreements if the Medi-Cal 2020 waiver and the WPC Pilot contract between DHCS and the County are extended.

Administrative Services Agreement

- Extend agreement consistent with any extension(s) to the Medi-Cal 2020 waiver and the WPC Pilot Contract between DHCS and the County;
- Extend administrative support consistent with any extension(s) to the Medi-Cal 2020 waiver and the WPC Pilot Contract between DHCS and the County or until funding to support such services are exhausted, whichever is earlier;
- Modify data sharing provision, subject to applicable privacy laws, to allow for continued data sharing for up to six (6) months following the local WPC pilot termination date to support trailing activities and member transitions to other programs; and
- Extend coordination support of a WPC Personal Care Coordinator through December 31, 2021 or until funding to support such services are exhausted, whichever is earlier.

Recuperative Care Grant Agreement

- Extend agreement consistent with any extension(s) to the Medi-Cal 2020 waiver and the WPC Pilot Contract between DHCS and the County or until IGT funding allocated for the recuperative care grant has been exhausted or WPC administration of recuperative care services are terminated; and
- Include contingency that should the WPC lose funding for the 50/50 cost split for recuperative care services, CalOptima continues reimbursement under the current terms and conditions, except increasing the CalOptima share to one hundred percent (100%), subject to IGT allocated funds availability.

County and CalOptima staff are collaborating on potential modification of criteria to support reimbursement for a longer time period. Additionally, CalOptima and County staff are collaborating to develop a business case for recuperative care as an in-lieu service, if eventually available under

CalAIM or other opportunity. CalOptima staff will return to the Board with further recommendations prior to making any request to DHCS for approval of recuperative care as an in-lieu service.

Fiscal Impact

The recommended action to extend and amend the WPC Administrative Services Agreement is budget neutral. Management has received $100,000 per pilot year to support PCC salary and benefits and enhancements to CalOptima's case management system. Only currently budgeted positions will be used to support the requirements of the WPC program, with no additional fiscal impact.

The recommended action to extend and amend the WPC Grant Agreement for Recuperative Care Services has no fiscal impact to CalOptima's operating budget. Payments for recuperative care services provided under the recommended actions are contingent upon the availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. 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

CalOptima has a long-standing relationship with the OCHCA. Both organizations share common goals of improving access to care and health care outcomes for vulnerable residents of Orange County. The WPC Pilot provides an opportunity to integrate systems of care and reduce inappropriate emergency department and inpatient utilization for CalOptima members experiencing homelessness.

Concurrence

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

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 1, 2017, Consider Authorizing Contracts with the Orange County Health Care Agency (OCHCA) and Other Participating Organizations for the Whole Person Care (WPC) Pilot
3. Board Action dated December 5, 2019, Consider Authorizing Reallocation of Intergovernmental Transfer Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or contract Amendment(s) with the County of Orange for Implementation, including as attachments Board Action dated September 7, 2017 Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members and Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7
4. Board Action dated June 4, 2020, Consider Authorizing a Grant Agreement with the County of Orange for Medical Respite Care

/s/ Richard Sanchez — *11/24/2020*
Authorized Signature — **Date**

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Attachment to the December 3, 2020 Board of Directors Meeting – Agenda Item 9

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
County of Orange	405 W 5th Street, Suite 756	Sana Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

38. Consider Authorizing Contracts with the Orange County Health Care Agency (OCHCA) and Other Participating Organizations for the Whole Person Care (WPC) Pilot

Contact

Candice Gomez, Executive Director Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with assistance of legal counsel, to contract with the Orange County Health Care Agency (OCHCA) for the Whole Person Care (WPC) pilot; and
2. Authorize the CEO, with assistance of legal counsel, to enter into information sharing agreements with other organizations participating in the Whole Person Care (WPC) pilot, subject to compliance with all applicable State and Federal privacy laws.

Background

On December 30, 2015 California's Department of Health Care Services (DHCS) received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015 to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

OCHCA collaborated with CalOptima, additional county agencies, hospitals, community clinics, community-based organizations and others to design and submit an application to DHCS for WPC in Orange County. Orange County's WPC pilot focuses on developing infrastructure and integrating systems of care during the first two years and enhanced services in subsequent years. The Pilot will target high utilizing Medi-Cal beneficiaries who are homeless members and those living with mental illness who are homeless or at risk of homelessness. OCHCA will used redirected funding and matching federal funds to implement Orange County's WPC pilot.

One of the DHCS requirements of the WPC Pilot application was for the county to include a letter of participation from the Medi-Cal managed care plan. On June 2, 2016, the CalOptima Board of Directors authorized CalOptima's participation with OCHCA in the WPC pilot program, including providing the OCHCA a letter of participation for the program.

OCHCA submitted its WPC pilot application to DHCS on July 1, 2016. CalOptima's commitment letter dated June 29, 2016 was included with OCHCA's application. DHCS approved OCHCA's initial application in October, 2016 for a total of $23.5 million over five

years. After allocating funds for the initial approved applications, DHCS solicited additional applications for the remaining funds available through the Waiver. On March 1, 2017, OCHCA submitted a supplemental application. DHCS is expected to announce awards for the supplemental applications on June 2, 2017. If approved, the total WPC pilot funding for Orange County would be $33,125,000. DHCS recently advised that contracts for WPC pilots must be executed by July 1, 2017.

Discussion

OCHCA's initial application was approved by DHCS in October 2016. Under the approved application and CalOptima's contract with OCHCA, CalOptima will receive $100,000 per year for 4 years to provide:

- Administrative support:
  - Physical space for meetings, as well as information systems and project management support for the workgroups;
  - Baseline data to facilitate goal setting and program development;
  - Data sharing about beneficiaries for better coordination of care, subject to applicable privacy laws, as well as HEDIS data to demonstrate improved outcomes for homeless, such as decreased ED visits and hospitalization, as well as increased utilization for prescription, professional and preventative services.
- Coordination support:
  - A WPC Personal Care Coordinator (PCC) to help homeless WPC beneficiaries and organizations supporting them, to navigate CalOptima, health networks and provider.

If OCHCA's supplemental application submitted on March 1, 2017 is approved on June 2, 2017, CalOptima will receive an additional $409,200 for CalOptima's case management system enhancements to support bi-directional communication and care plan sharing.

To participate in WPC, CalOptima is required to enter an agreement with OCHCA. Additionally, and in compliance with all applicable State and Federal privacy laws, CalOptima anticipates entering into agreements with various entities participating in the WPC to support information sharing (e.g., contracts including Business Associate Agreements). These participating entities include, for example, OCHCA's vendor providing the platform for bi-directional information sharing, recuperative care providers, and community-based organizations providing services to beneficiaries who are homeless, at risk of homelessness and/or having mental illness.

Fiscal Impact

The fiscal impact of the recommended action to authorize contracts with the OCHCA and other participating organizations for the WPC pilot is expected to be budget neutral. Management anticipates receiving up to $809,200 over the four year period of the proposed WPC pilot to support PCC salary and benefits and enhancements to CalOptima's case management system. Only currently budgeted positions will be used to support the requirements of the WPC pilot's implementation, with no additional fiscal impact anticipated.

Rationale for Recommendation

CalOptima has a long-standing relationship with the Orange County Health Care Agency. The two entities share common goals of improving access to care and health care outcomes for vulnerable residents of Orange County. The WPC Pilot provides an opportunity to integrate systems of care and reduce inappropriate emergency department and inpatient utilization for CalOptima's highest-risk members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated June 2, 2016, Authorize Participation with the Orange County Health Care Agency in the Department of Health Care Services Whole Person Care Pilot Program
2. June 29, 2016 CalOptima Letter of Participation to the Orange County Health Care Agency for Whole Person Care Pilot Program

/s/ Michael Schrader — *5/25/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Authorize Participation with the Orange County Health Care Agency in the Department of Health Care Services (DHCS) Whole Person Care (WPC) Pilot Program

Contact

Cheryl Meronk, Director, Strategic Development, (714) 246-8400
Arif Shaikh, Director, Public Policy and Government Affairs, (714) 246-8400

Recommended Action

Authorize participation with the Orange County Health Care Agency (HCA) in the DHCS WPC Pilot program, including providing the HCA with a letter of participation for the program.

Background

On December 30, 2015 California's Department of Health Care Services (DHCS) received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015 to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. On April 7, 2016, the Orange County Health Care Agency submitted a Letter of Intent (LOI) to DHCS to participate in the WPC Pilot.

Discussion

As per the LOI, the county aims to focus its WPC Pilot on developing infrastructure and integrating systems of care for high utilizing Medi-Cal beneficiaries who access county mental health services, substance use disorder services, and homeless services programs, and also have high instances of emergency room and inpatient utilization. One of the requirements of the DHCS WPC Pilot application is for the county to include a letter of participation from the Medi-Cal managed care plan. The WPC Pilot application must be submitted by July 1, 2016.

CalOptima's participation in the county's WPC Pilot, subject to full compliance with all applicable privacy laws applicable to CalOptima, will focus on the following areas:

- Entering into agreements with the county to share data about beneficiaries for better coordination of care
- Coordination with CalOptima's contracted health networks and providers to identify members who can benefit from WPC Pilot initiatives
- Working with the county and other entities associated with the WPC Pilot to analyze the effectiveness of the program as it relates to emergency department and inpatient utilization trends

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Fiscal Impact

CalOptima does not anticipate incurring material operating expenses related to the recommended action to provide Orange County Health Care Agency with a letter of participation for the DHCS WPC pilot program. As program parameters are finalized, staff will keep the Board updated on the level of staffing resources committed.

Rationale for Recommendation

CalOptima has a long-standing relationship with the Orange County Health Care Agency. The two entities share common goals of improving access to care and health care outcomes for vulnerable residents of Orange County. The WPC Pilot provides an opportunity to integrate systems of care and reduce inappropriate emergency department and inpatient utilization for CalOptima's highest-risk members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Letter of Participation to the Orange County Health Care Agency for WPC
2. Orange County Health Care Agency LOI to DHCS for WPC
3. Whole Person Care (WPC) Pilot Program (DHCS PowerPoint)

/s/ Michael Schrader — *5/26/2016*

Authorized Signature — **Date**

CalOptima
A Public Agency
Better. Together.

June 2, 2016

Mark Refowitz
Director
Orange County Health Care Agency
405 W. 5th Street, 7th Floor
Santa Ana, CA, 92610

Dear Mr. Refowitz:

This letter is to confirm CalOptima's commitment and participation in the Whole Person Care (WPC) Pilot as the Medi-Cal managed care plan for Orange County, subject to full compliance with all applicable privacy laws applicable to CalOptima.

As specified in the WPC application being submitted by the County of Orange as the lead entity, CalOptima is committed to working in partnership with the County in implementing the WPC Pilot. The pilot will focus on developing infrastructure and integrating systems of care for our members who are homeless or at risk of homelessness, and will also specifically target those who are also seriously mentally ill. Additionally, we look forward to the impact of our collaboration with all the participating entities in improving health outcomes for these members.

We are particularly encouraged by the potential of the WPC Pilot to improve data sharing across the participating entities in order to better coordinate care. We believe that certain infrastructure components included in the WPC Application have broader relevance to helping serve all Medi-Cal beneficiaries served by CalOptima and we eagerly await the results of their implementation and evaluation in this pilot opportunity.

Thank you for your role as the lead entity and we look forward to working with you and the other collaborative partners on this program.

Sincerely,

Michael Schrader
Chief Executive Officer

MARK A. REFOWITZ
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SANTA ANA, CA 92701
FAX: (714) 834-5506

ochealth CARE AGENCY

OFFICE OF THE DIRECTOR

April 7, 2016

TO: Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services

SUBJECT: **Whole Person Care Pilot Letter of Intent**

Pursuant to instructions dated March 18, 2016, this serves as the Letter of Intent, on behalf of Orange County, for our participation in the Whole Person Care (WPC) pilot. .

Lead Entity Contact Information:

1. Lead Entity Name and Mailing Address is:
   Orange County Health Care Agency, 405 W 5th St, Santa Ana, CA 92701.
2. Point of Contact Name, E-mail Address, and Telephone Number is:
   Melissa Tober, Special Projects Manager, mtober@ochca.com , (714) 834-5891

Preliminary WPC Pilot Design:

1. ***Include a statement about your organization's interest in participating in a WPC pilot.***

   The Orange County Health Care Agency (HCA) is keenly interested in WPC pilot participation based upon our successful collaboration with the DHCS on the Coverage Initiative Program and later the Low Income Health Program. In both of these instances, our collaboration enhanced our working relationship with DHCS, enhanced health care outcomes for vulnerable populations in Orange County, and led to a more efficient transition into Medi-Cal for those populations that are now covered pursuant to the Medi-Cal expansion (MCE) transition.

   HCA believes that through our collaboration on WPC we will, similarly, be able improve outcomes for hard to serve populations, improve care coordination, and increase access to needed social and supportive services through the policies that the DHCS has articulated for WPC.

2. ***Describe the geographic area in which the WPC pilot would operate and the target population(s) for the pilot.***

   - Geographic area: HCA is committed to a collaborative process with local stakeholders about all program parameters relating to WPC. Nonetheless, HCA assumes that the initial geographic focus will be on areas of high Medi-Cal enrollment and high utilization of county mental health, homeless services, and substance use disorder services, and also have high instances of emergency room and inpatient utilization. In Orange County, those areas include primarily Santa Ana, Garden Grove, and Anaheim (with a combined population of over one million people). It is expected, however, that this is an initial focus and during the five-year term of the WPC, other areas of Orange County will be included.

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- Population: Subject to a collaborative process with Orange County partners, HCA believes that WPC will be focused on high utilizing Medi-Cal beneficiaries who access county mental health services, substance use disorder services, and homeless services programs, and also have high instances of emergency room and inpatient utilization.

3. ***List the potential participating entities that would work in partnership with your organization as part of the WPC pilot. Indicate if the entity is a managed care plan, a health services and specialty mental health agency/department, a public agency/department, or a community partner.***

- Orange County Health Care Agency – Lead Entity and also includes:
  - County Behavioral Health (Mental Health and Substance Abuse).
  - County Public Health.
- Orange County Community Resources, which includes:
  - Homeless Prevention Program.
  - Orange County Housing Authority.
  - Veterans Service Office.
- Orange County Social Services Agency.
- CalOptima – the County Organized Health System (COHS) serving Orange County.
- Orange County 211 – A nonprofit offering a comprehensive information and referral system.
- Share Our Selves – A nonprofit FQHC that is also the only community health center in Orange County with a federal designation as a Healthcare for Homeless provider.
- Illumination Foundation – A nonprofit Orange County homeless community provider.
- Others as may be identified during the collaboration process.

4. ***Describe possible interventions and infrastructure that the WPC pilot may implement:***

With respect to infrastructure and data sharing, Orange County is evaluating, with plans to be more definitive in its application:

- Expanding the Homeless Management Information System currently managed by Orange County 211 to include a public health/health module.
- Re-tooling an electronic referral system, previously used for the Low Income Health Program, to link homeless beneficiaries to a care coordination team following an emergency room visit or inpatient admission. This process would happen in real time, allowing the necessary resources to reach the beneficiary when they are at their most vulnerable and have the highest need.
- Establishing/strengthening existing care coordination efforts among the participating entities, through data sharing/coordination.
- Other options as may be raised during the collaborative process, including the local 911 system.

With respect to care not currently reimbursed by Medicaid, Orange County is evaluating, with plans to be more definitive in its application:

- Expansion of recuperative care, a program that provides short- term medical care and care management to homeless persons who are recovering from an acute illness or injury, and whose conditions would be exacerbated by living on the street or in a shelter.
- Establishing medical bridge housing.
- Peer support services, including but not limited to transportation to medical appointments and in-home support services.

- Additional wrap-around and supportive services that not only facilitate a beneficiary's ability to obtain permanent housing, but also allow them to maintain their housing.
- Other options as may be raised during the collaborative process.

5. ***Note whether or not the WPC pilot would provide housing and supportive services to the target population(s):***

   Please see the response to question 4 with respect to supportive services which includes recuperative care and medical bridge housing, as well as wraparound and supportive services to the beneficiary. In addition to supporting the beneficiary to obtain and maintain housing, to the extent that the policies of the WPC Pilot allow, creative solutions to identifying housing options and opportunities will also be explored during the collaboration process. Orange County's rental vacancy rate is 1% to 2%, compared to 4% for California as a whole, placing available rental housing at a premium and causing rents to increase.

Thank you for this opportunity.

Mark A. Refowitz, Director

DG/RS/MAR:mh 16-034

cc: Frank Kim, County Executive Officer
Mark Denny, Chief Operating Officer

Whole Person Care (WPC) Pilot Program

Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services

May 16, 2016

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Presentation Overview

1. WPC Program Overview
2. Key Elements of the WPC Pilots
   - Goals and Strategies
   - Lead and Participating Entities
   - Target Populations
   - Activities/Services
3. Letters of Intent
4. STC Attachments
   - Universal Metrics
   - Variant Metrics
5. Implementation Activities
6. Application Elements and Timeline
7. Questions/Open Discussion

WPC Program Overview

Program Duration

- 5-year program authorized under the Medi-Cal 2020 waiver

Goal

- To test locally-based initiatives that will coordinate physical health, behavioral health, and social services for beneficiaries who are high users of multiple health care systems and have poor outcomes

Funding

- Up to $1.5 billion in federal funds available to match local public funds over 5 years
- Up to $300 million annually is available
- Based on semi-annual reporting of activities/interventions
- Non-federal share provided via Intergovernmental Transfers (IGT)

Goals and Strategies

Increase:

- Integration among county agencies, health plans, providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries
- Coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries
- Access to housing and supportive services

Reduce:

- Inappropriate emergency department and inpatient utilization

Goals and Strategies

Develop:

- An infrastructure that will ensure local collaboration among the entities participating in the WPC pilots over the long term

Improve:

- Health outcomes for the WPC population
- Data collection and sharing among local entities

Achieve:

- Targeted quality and administrative improvement benchmarks

Lead Entities

Lead Entities:

- County
- A city and county
- A health or hospital authority
- A designated public hospital
- A district/municipal public hospital
- A federally recognized tribe
- A tribal health program under a Public Law 93-638 contract with the federal Indian Health Services
- A consortium of any of the above entities

Lead Entity Responsibilities:

- Submits Letter of Intent and application
- Serves as the contact point for DHCS
- Coordinates WPC pilot
- Collaborates with participating entities

Participating Entities

Participating Entities must include at least:

- One (1) Medi-Cal managed care health plan
- One (1) health services agency/department
- One (1) specialty mental health agency/department
- One (1) public agency/department
- Two (2) community partners

Participating Entity Responsibilities:

- Collaborates with the lead entity to design and implement the WPC pilot
- Provides letters of participation
- Contributes to data sharing/reporting

Lead and Participating Entities

- Lead entities indicate in the application who the participating entities will be.
  - DHCS encourages a collaborative approach.
- Only one Medi-Cal managed care plan is required to participate, but DHCS encourages including multiple plans.
  - Medi-Cal managed care plan participation must include the plan's entire network (i.e., where delegation of risk has occurred to an entity in the plan's network).
  - Specific exclusions and exceptions may be considered on a case-by-case basis.
- Lead entities cannot also be one of the two required community partners.

Target Populations

WPC pilots identify high-risk, high-utilizing Medi-Cal beneficiaries in their geographic area.

- Work with participating entities to determine the best target population(s) and areas of need.

Target population(s) may include, but are not limited to, individuals:

- with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
- with two or more chronic conditions;
- with mental health and/or substance use disorders;
- who are currently experiencing homelessness; and/or
- who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g., hospital, skilled nursing facility, rehabilitation facility, jail/prison, etc.).

Letters of Intent

- DHCS released instructions for a Letter of Intent (LOI) in March 2016.
- The purpose of the LOI was to gauge the level of interest, obtain preliminary program design, and provide an opportunity for entities to submit questions
  - Submission of an LOI was voluntary and will not preclude lead entities from applying when the WPC application is released.
- 29 LOIs were received from 28 counties.

Letters of Intent

	Lead Entity	Geographic Area
1	Alameda County Health Care Services Agency	Alameda County, with concentration in the "880 corridor" stretching from Oakland to Hayward
2	Arrowhead Regional Medical Center	San Bernardino County
3	Calaveras County Health and Human Services Agency	Calaveras County
4	California Rural Indian Health Board (CRIHB)	Statewide
5	Contra Costa Health Services	Contra Costa County (Urban areas)
6	County of Imperial Public Health Department	Imperial County (geographic area TBD)
7	County of San Mateo Health System	San Mateo County
8	Humboldt County Department of Health and Human Services	Humboldt County
9	Kern Medical Center	Kern County (Individuals residing within a 15 mile radius of KMC and/or their assigned medical home)
10	Kings County Department of Public Health	Kings County
11	Los Angeles County	Los Angeles County in all 8 county service planning areas
12	Mathiesen Memorial Health Clinic	Calaveras,Tuolumne, and Mariposa Counties
13	Mendocino County Health & Human Services Agency	Mendocino County
14	Monterey County Health Department	Monterey County
15	Orange County Health Care Agency	Orange County with focus on areas of high Medi-Cal enrollment and high utilization of county resources (primarily Santa Ana, Garden Grove, and Anaheim)

Letters of Intent

	Lead Entity	Geographic Area
16	Placer County Health and Human Services	Placer County
17	Riverside University Health System Department of Population Health	Riverside County
18	San Benito County Health and Human Services Agency	San Benito County
19	San Diego County Health and Human Services Agency	San Diego County
20	San Francisco Department of Public Health	City of San Francisco
21	San Joaquin County Health Care Services Agency	San Joaquin County – (initial targets Stockton and Lathrop areas with entire county by demo end)
22	Santa Clara Valley Health and Hospital System	Santa Clara County
23	Shasta County Health and Human Services Agency	Shasta County
24	Solano County Health and Social Services	Solano County
25	Southern Indian Health Council	San Diego County (rural southeast)
26	Tulare County Health and Human Services Agency	Tulare County
27	Ventura County Health Care Agency	Ventura County
28	WellSpace Health	Sacramento
29	Yolo County Health and Human Services Agency	Yolo County

- The list of the lead entities that voluntarily submitted LOIs can also be found at the following link: http://www.dhcs.ca.gov/services/Documents/WPCLOISubmissions.pdf.

Activities/Services

Generally, WPC pilot payments may support activities that:

- **Build infrastructure** to integrate services among local entities that serve the target population.
- **Provide services not otherwise covered or directly reimbursed by Medi-Cal** to improve care for the target population, such as housing components.*
- **Implement strategies** to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

*Federal WPC payments are not available for services provided to non-Medi-Cal beneficiaries.

Activities/Services Examples

- Care coordination
- Recuperative care/medical respite
- Sobering centers
- Transportation
- Field-based care, such as case managers, therapists, or nurses delivering services on the street or in the home
- New IT infrastructure

Activities/Services: Housing Supports & Services

WPC pilots for Housing Supports/Services:

- May target individuals who are experiencing, or are at risk of, homelessness who have a demonstrated medical need for housing or supportive services.
- Must have participating entities that include local housing authorities, local continuum of care program, and community-based organizations serving homeless individuals.

Activities/Services: Housing Supports & Services

Federal Medicaid funds may not be used to cover the cost of:

- Room and board
- Monthly rental or mortgage expense
- Food
- Regular utility charges
- Household appliances or items that are intended for purely diversional/recreational purposes

However, state or local government and community entity contributions that are not used to match WPC pilot federal financial participation (FFP) may be allocated to fund support for long-term housing, including rental housing subsidies.

Activities/Services: Housing Supports & Services

Eligible Housing Supports & Services include:

- Individual Housing Transition Services: housing transition services to assist beneficiaries with obtaining housing, such as individual outreach and assessments.
- Individual Housing & Tenancy Sustaining Services: services to support individuals in maintaining tenancy once housing is secured, such as tenant and landlord education and tenant coaching.
- Additional transition services, such as searching for housing, communicating with landlords, and coordinating moves.

Activities/Services: Housing Supports & Services

Additional transition services:

- Transportation
- Environmental accommodations for accessibility
- Housing transition services beyond case management services that do not constitute room and board, such as:
  - Security deposits
  - Utility set-up fees
  - First month coverage of utilities
  - One-time cleaning prior to occupancy, etc.

Activities/Services: Flexible Housing Pool

The flexible housing pool:

- May include funding created from savings generated by reductions in health, behavioral, and acute care costs, which result from WPC pilot housing-related strategies.
- Can be used to fund additional supports and services that are not available for (FFP), such as rental subsidies, home setup, deposits, and utilities.

STC Attachments

- There are three Special Terms and Conditions (STC) protocols related to Whole Person Care:
  - Attachment GG – Reporting and Evaluation
  - Attachment HH – WPC Pilot Requirements and Application Process
  - Attachment MM – WPC Pilot Requirements and Metrics
- Attachment MM describes the universal and variant metrics that WPC pilots are required to report on.

Universal Metrics

All WPC are required to report on the same set of universal metrics.

- These include four (4) health outcomes measures and three (3) administrative measures.
- **Health Outcomes Measures:**
  - 1. Ambulatory Care
  - 2. Inpatient Utilization
  - 3. Follow-up After Mental Health Illness Hospitalization
  - 4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **Administrative Measures:**
  - 1. Comprehensive Care Plan
  - 2. Care Coordination, Case Management, and Referral Infrastructure
  - 3. Data and Information Sharing Infrastructure

Variant Metrics

Variant metrics are specific to the WPC target population(s), strategies, and interventions.

- Each WPC Pilot must report on a minimum of four (4) variant metrics, including:
  - 1. One administrative metric in addition to the Universal care coordination and data sharing metrics
  - 2. One standard health outcomes metrics (e.g., HEDIS) applicable to the WPC Pilot population across all five program years for each target population
  - 3. WPC Pilots utilizing the PHQ-9 shall report the Depression Remission at Twelve Months (NQF 0710) metric; all other Pilots shall report one alternative health outcomes metric.
  - 4. WPC Pilots including a severely mentally ill (SMI) target population must report on the Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) WPC Pilots; all other Pilots shall report one alternative health outcomes metric.
- WPC Pilots implementing a housing component must report a metric specific to the housing intervention.

Implementation Activities To Date

Completed

- Issued frequently asked questions (FAQs); continually updated as clarifications must be made
- Conducted FAQ webinar
- Released Letter of Intent to gauge level of interest; collected responses
- Released draft application and selection criteria
- Public comment on draft application and selection criteria
- Submitted selection criteria to CMS for approval

Next Steps

- Finalize Attachment MM (metrics protocol) with CMS
- Issue all three protocols (Attachment GG, Attachment HH, and Attachment MM) as final
- Submit valuation outline prior to releasing application
- Release final application and selection criteria
- Conduct application webinar
- Review applications which are due July 1
- Convene a Learning Collaborative

WPC Application Elements

The WPC application must provide information on:

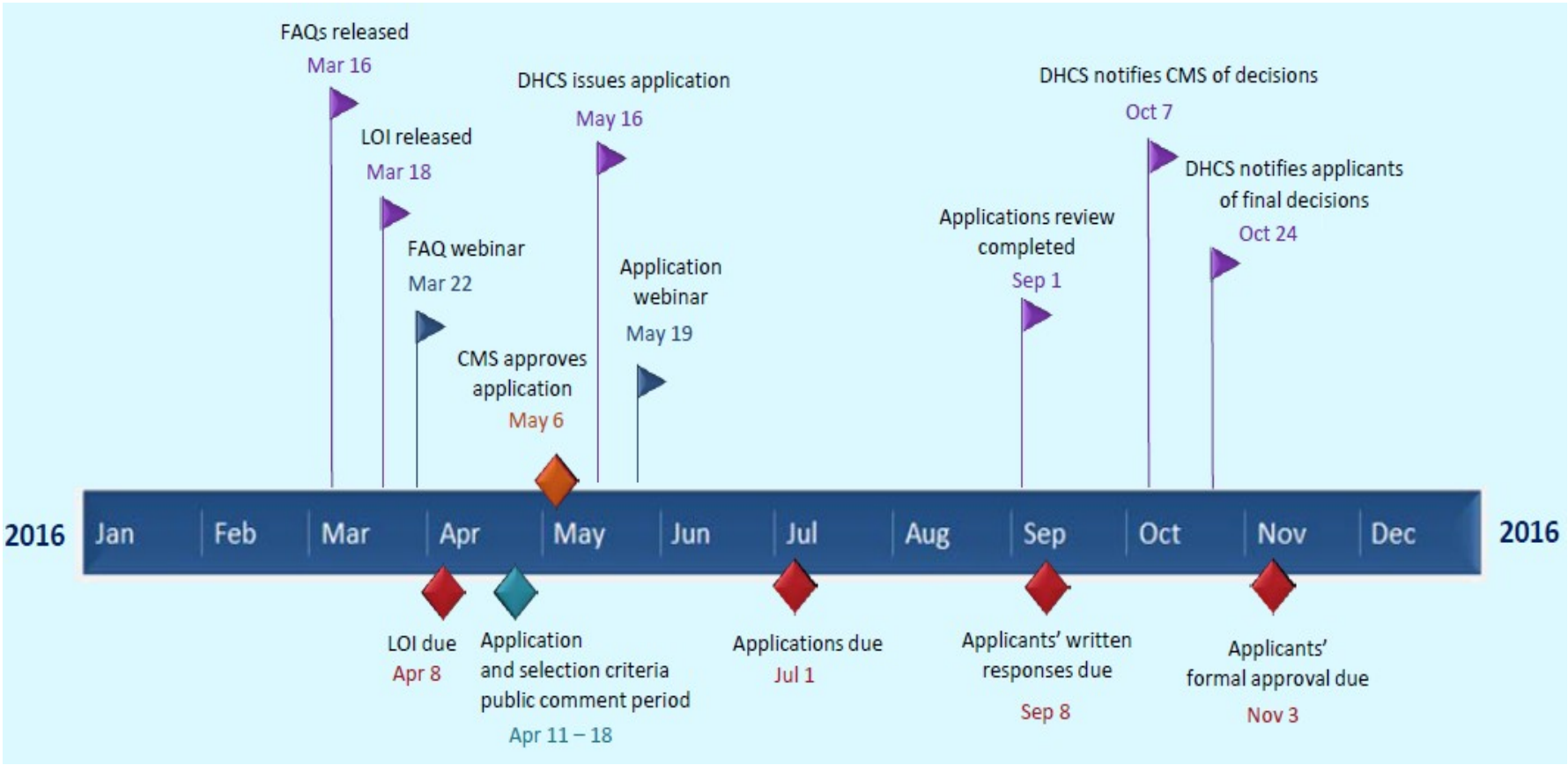
- The target population of the WPC pilot
- Services, interventions, and strategies that will be used for each target population
- How data sharing will occur between the participating entities
- The performance measures the WPC pilot will use to track progress
- The plan for collecting, reporting, and analyzing data
- How monitoring of the participating entities' performance will occur

WPC Application Elements (cont'd)

The WPC application must provide information on:

- The universal and variant metrics that the WPC pilots will report on
- The WPC pilot financing structure, including the funding flow to the lead entity and participating entities
- The total requested funding amount to operate the WPC pilot
- An attestation for the WPC pilot lead entity to participate in learning collaboratives to share best practices among pilot entities

Application Timeline



Resources

Visit our webpage:

- http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

Submit questions/sign up for the listserv:

- 1115WholePersonCare@dhcs.ca.gov

Questions and Discussion

CalOptima
A Public Agency
Better. Together.

June 29, 2016

Sarah Brooks
Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95814

Dear Ms. Brooks:

This letter is to confirm CalOptima's commitment and participation in the Whole Person Care (WPC) Pilot as the Medi-Cal managed care plan for Orange County, subject to full compliance with all applicable privacy laws applicable to CalOptima.

As specified in the WPC application being submitted by the County of Orange as the lead entity, CalOptima is committed to working in partnership with the County in implementing the WPC Pilot. The pilot will focus on developing infrastructure and integrating systems of care for our members who are homeless or at risk of homelessness, and will also specifically target those who are also seriously mentally ill. Additionally, we look forward to the impact of our collaboration with all the participating entities in improving health outcomes for these members.

We are particularly encouraged by the potential of the WPC Pilot to improve data sharing across the participating entities in order to better coordinate care. We believe that certain infrastructure components included in the WPC Application have broader relevance to helping serve all Medi-Cal beneficiaries served by CalOptima and we eagerly await the results of their implementation and evaluation in this pilot opportunity.

We look forward to working with the other collaborative partners on this program.

Sincerely,

Michael Schrader
Chief Executive Officer

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Reallocation of Intergovernmental Transfer Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or Contract Amendment(s) with the County of Orange for Implementation

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize reallocation of $2.5 million from the $10 million previously allocated IGT 6 and 7 funds of the total of $11 million allocated for recuperative care and medical respite program to housing supportive services for CalOptima Medi-Cal members;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to
    a. Amend CalOptima's current agreement with the County of Orange as necessary to allow for reallocation of funds previously allocated to recuperative care for CalOptima members under the County's Whole Person Care (WPC) Pilot Program; and
    b. Enter into a new agreement or amend CalOptima's current agreement with the County of Orange to include housing supportive services for qualifying CalOptima members.

Background

The WPC Pilot is an Orange County-operated pilot program, administered by the Orange County Health Care Agency (OCHCA), that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. The County of Orange's WPC Pilot application was approved by the Department of Health Care Services (DHCS) in October 2016 and coordinates physical, behavioral health, and social services in a patient-centered approach with the goals of improved and health and well-being through more effective use of resources. The WPC Pilot provides housing supportive services which includes housing navigation and tenancy sustaining services. Additional funding was provided to the WPC Pilot in January 2019 allocating funds specifically to expand existing WPC housing navigation and supportive services for persons living with serious mental illness as well as implement these services for persons who do not have a connection to OCHCA Behavioral Health Services. The WPC Pilot also includes provisions for recuperative care services for up to a maximum of 90 days based on medical need. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. 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. DHCS approved use of IGT 6 and IGT 7 funds to provide enhanced services to CalOptima Medi-Cal members in the following areas: opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the

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safety net, children's health, older adult health and other areas as identified by a member health needs assessment.

During the August 2, 2018 CalOptima Board of Directors (Board) meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. While community proposals were solicited, the Board made a grant allocation of up to $10 million from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for CalOptima members experiencing homelessness under the County's WPC Pilot in addition to the $1 million earlier allocated for recuperative care for CalOptima members experiencing homelessness and being discharged from a hospital setting. On April 4, 2019 the Board authorized reallocation of $250,000 from the $10 million IGT 6 and 7 recuperative care fund towards a Medical Respite Program for CalOptima Medi-Cal members meeting medical criteria beyond the 90 days available for recuperative care through the WPC Pilot.

On October 28, 2019 DHCS released the initial CalAIM proposal. While this proposal may be further refined prior to implementation, as proposed, it could significantly impact the future Medi-Cal delivery system. One proposed impact would be for Medi-Cal managed care plans, including CalOptima, to provide recuperative care as an In Lieu of Service potentially beginning as soon January 1, 2021. The County of Orange has determined that of the $9.75 million IGT 6 and 7 funding allocated by the CalOptima Board towards recuperative care, at least $2.5 million dollars can be reallocated toward other services without impacting the availability of recuperative care services for CalOptima members.

Discussion

Housing supportive services encompass housing navigation and sustaining services that include client assessments to identify barriers to housing placement and working with both landlords and members to sustain tenancy. Housing supportive services are incorporated into the member's individualized care plan that integrates all physical, behavioral, and social service needs. This member-centric supportive approach assists the individual to integrate into community-based settings which enhances their ability to be a good neighbor to the rest of the community.

The County of Orange provides housing supportive services to those who quality for the WPC Pilot and/or are linked to the County's Behavioral Health Services Program; however, there continue to be individuals who do not quality for services through these programs. In November 2019, OCHCA established a funding pool which is intended to address funding gaps for those needing but not receiving housing supportive services. In order to support these efforts, CalOptima staff recommends reallocating up to $2.5 million in IGT 6 and 7 funds previously allocated for recuperative care for CalOptima members to housing supportive services for CalOptima members. As proposed, these reallocated IGT 6 and 7 funds would be available to reimburse the OCHCA for housing supportive services provided to CalOptima members receiving services through WPC once WPC funding has been exhausted, or for CalOptima members not receiving services through WPC but in need of housing supportive services. CalOptima members enrolled in the Health Homes Program would be excluded as CalOptima is

coordinating with OCHCA to develop a separate agreement for members enrolled in the Health Homes Program.

The County of Orange contracts with vendors to provide housing supportive services. Services contracted vendors are required to provide, when appropriate, include but are not limited to the following:

- Match WPC clients with a housing voucher to appropriate housing resources or provide navigation services to those who do not have housing vouchers;
- Act as a liaison in collaboration with and between the WPC client and landlord;
- Transport or arrange for transportation of WPC clients to potential housing placement opportunities;
- Assist with the housing application process;
- Secure reasonable letters of support as needed;
- Ensure that the WPC client has a security deposit for housing and utilities;
- Ensure that the WPC client becomes a resident after housing placement;
- Arrange for utilities to be turned on;
- Educate WPC clients on housekeeping issues and "good neighbor" issues such as maintenance, community living, and independent living skills;
- Coach WPC clients in order to have successful interactions when meeting with potential property managers, and prepare them for placement; and
- Link WPC clients to peer mentoring and other sustainability services for ongoing support in an effort to further ensure housing sustainability.

Contracted housing supportive services vendors are approved and reimbursed for six months on a per member per month capitated basis. Individuals are reevaluated every six months and services continue until it is determined that the individual no longer requires housing supportive services. As proposed, CalOptima would reimburse the County for housing supportive services provided to qualifying CalOptima members on a per member per month basis.

Fiscal Impact

The recommended actions to authorize reallocation of up to $2.5 million in IGT 6 and 7 funds to housing supportive services for qualifying CalOptima members has no fiscal impact to CalOptima's Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. 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 Medi-Cal health plan for Orange County, collaborates with our provider, community, and county partners to address the healthcare needs of CalOptima members and work to improve the availability, access, and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
3. CalOptima Board Action dated April 4, 2019, Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program
4. California Advancing and Innovating Medi-Cal (CalAIM) Executive Summary

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

Attachment to December 5, 2019 Board of Directors Meeting - Agenda Item 14

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
County of Orange	405 W 5th Street, suite 756	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. 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, is committed to working 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 for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

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

9/25/2015 — **Date**

CalOptima
A Public Agency
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IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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Attachment to December 5, 2019 Board of Directors Meeting -- Agenda Item 14

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Contacts

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate;
2. Authorize reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program.

Background

The WPC is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. 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. DHCS approved use of IGT 6 and IGT 7 funds to support programs addressing the following areas: Community health investments which may include programs addressing opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by a member health needs assessment. At the August 2, 2018 Board of Directors meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. A grant allocation of up to $10 million was approved from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for homeless CalOptima members under the WPC

pilot. The funds are currently designated for funding 50 percent of medically justified recuperative care bed days up to a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available. The CalOptima Board of Directors also approved an amendment of the agreement with the County of Orange to include indemnity language and allowing for use of the allocated funds for recuperative care services under the County's WPC Pilot program for qualifying homeless CalOptima members.

Discussion

Since 2016, the OCHCA has collaborated with CalOptima and other community-based organizations, community clinics, hospitals, and county agencies to design and implement the WPC Pilot program. The recuperative care element of the WPC pilot is a critical component of the program. During calendar year 2018, the WPC recuperative care program provided services to 487 unique CalOptima members experiencing homelessness. Between August and December 2018, the average length of stay for these individuals was 34 days, at a cost of $705,250.

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy but do not qualify for transition to skilled nursing care, may benefit from medical respite care beyond the 90 days of recuperative care.

To address this concern, CalOptima staff, with the support of OCHCA WPC staff, and consistent with the approved IGT 6/7 funding categories, is proposing to develop a Medical Respite Program for CalOptima members who need extended medical care beyond the 90 days as provided under the current scope of the WPC Pilot to achieve and maintain medical stability. Staff is in the process of developing policies related to the proposed medical respite program, the purpose of which is to provide short-term residential care to allow individuals with unstable living situations the opportunity to rest in a safe and clean environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite care seeks to improve transitional care for the population and to aid in ending the cycle of homelessness while also gaining stability with case management relationships and programs. As appropriate, staff will seek state approval of this new Medical Respite Program, which is intended to support homeless CalOptima members as they recover and attain medical stability, or in the case of members in hospice, to receive services in a stable environment care. The additional time beyond the days available through the County's WPC program is intended to reduce inappropriate and/or avoidable utilization of hospital Emergency Departments, inpatient admissions and re-admissions.

CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis and will need approval by County WPC staff, County Medical Safety Net (MSN) program nurses and CalOptima to be eligible for the Medical Respite Program. Regular reviews and updates will be conducted by the MSN program nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical

stability and steps to move to a skilled nursing facility (SNF), if appropriate. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. CalOptima will monitor utilization and member outcomes.

In addition, staff is seeking authority to reallocate $250,000 out of the $10 million the Board allocated to OCHCA WPC program for recuperative care to fund the Medical Respite Program. In other words, no new funding is being proposed. Instead, the recommendation for authority is to redirect dollars previously committed for recuperative care for homeless CalOptima members in coordination with the County's WPC program. Staff is also seeking authority to provide the OCHCA with reimbursement for the full cost of the Medical Respite Program stay at $120 per day, for all bed days beyond the WPC Pilot recuperative care program, not to exceed the requested reallocation amount of $250,000. The OCHCA supports the recommended actions and plans to continue to invoice CalOptima for members in the Medical Respite Program via a similar process such as the already established invoicing process for recuperative care. The funds will be available through the end of the WPC Pilot or until the funds are exhausted, whichever comes first.

Fiscal Impact
The recommended actions to authorize the creation of a Medical Respite Program for CalOptima members and to authorize a reallocation of $250,000 from the $10 million IGT allocation to Orange County Health Care Agency (OCHCA) for recuperative care services, previously approved by the Board on August 2, 2018, 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. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
2. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CalOptima Board Action Agenda Referral

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. 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, is committed to working 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 for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

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

9/25/2015 — **Date**

CalOptima
A Public Agency
Better. Together.

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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:

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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**

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California Advancing and Innovating Medi-Cal (CalAIM)
Executive Summary

The Department of Health Care Services (DHCS) has developed a framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduce health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on an individual's health and quality of life, and through iterative system transformation, ultimately reduce the per-capita cost over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are initial proposals whose implementation will ultimately depend on whether funding is available.

Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.). As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and

align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

To achieve such outcome, CalAIM proposals offer the solutions to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees. CalAIM seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life. To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and make system changes necessary to close the gap in transitions between delivery systems, opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles. For the purposes of CalAIM DHCS built off and refined those principles to guide the work we intended to pursue.

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities or inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Key Goals

To achieve such principles, CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The reforms of CalAIM are comprehensive and critical to the success of the delivery system transformation necessary to improve the quality of life for Medi-Cal members as well as long-term cost savings/avoidance that will not be possible to achieve absent these initiatives. Furthermore, these reforms are interdependent and build off one another; without one, the others are not either possible or powerful. Below is an overview of the various proposals and recommendations that make up CalAIM.

Identify and Manage Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the State's health care delivery system aimed at achieving better care, better health and reduced expenditures in Medi-Cal programs. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, as well as chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve such goals, DHCS proposes the following recommendations that focus on a whole-person care approach that addresses the needs of our beneficiaries across the board – looking at physical and behavioral as well as social determinants of health, with the overarching goals of improving quality of life and reducing the overall costs for the Medi-Cal population.

- Require plans to submit local population health mangement plans.
- Implement new statewide enhanced care management benefit.
- Implement in lieu of services (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Evaluate participation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
- Require screening and enrollment for Medi-Cal prior to release from county jail.
- Pilot full integration of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for foster care children and youth.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a patient-centered population health strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall include, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;

- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care pilots, and transitions those pilots to this new statewide benefit to provide a broader platform to build on positive outcomes from those programs.

Target populations include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;
- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
- Individuals transitioning from incarceration; and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under Whole Person Care, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a managed care plan will integrate into its population health strategy. These services are provided as a substitute, or to avoid, other services such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with Case or Care Management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health needs. Examples of in lieu of services include but are not limited to: housing transition and sustaining services, recuperative care, respite, home and community based wrap around services for beneficiaries to transition or reside safely in their home or community, and sobering centers.

The use of in lieu of services are voluntary, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building an integrated managed long-term services and supports (MLTSS) managed care program by 2026 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the State must use its ability to provide our Medi-Cal managed care plans with financial incentive payments established to drive plans and providers to invest in the necessary

delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

Institutions for Mental Disease (IMD) Expenditure Waiver

Currently, federal Medicaid funding cannot be used for institutional services provided to individuals with serious mental illness or severe emotional disturbance (known as the IMD exclusion). However, the federal government has developed an opportunity for states to seek the ability to receive federal funding for institutional services provided to these populations. Through extensive stakeholder engagement, DHCS will assess state and county interest in pursuing the IMD expenditure waiver, as well as readiness of our systems to achieve the required goals and outcomes. Such a proposal must be budget neutral and would allow counties to "opt-in." The main elements of any proposed waiver would include:

- Ensuring quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this waiver opportunity, counties that "opt in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail

Justice involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs are met like housing, transportation and overall integration back into the community. Studies have shown, such coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. In an effort to ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate the county inmate pre-release Medi-Cal application process by January 2022. Additionally, DHCS is proposing to mandate all counties implement warm-handoffs from county jail release to county behavioral health departments when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial

considerations due to realignment and Prop 30 implications. Given the complexity of this proposal, DHCS assumes the selected plans would not go live until 2024, as DHCS and our managed care plans and county partners work together to develop the most appropriate delivery systems for this purpose.

Develop a Long-Term Plan for Foster Care

In 2020, DHCS would like to form a group of stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. Based on the recommendations from such workgroup, DHCS, California Department of Social Services, and other sister departments would work to implement such changes based on timelines developed in the stakeholder process.

Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services are different depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental and other county based services.
To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance accredited
- Implement annual Medi-Cal health plan open enrollment
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
- Administrative behavioral health integration statewide
- Regional contracting
- Substance use disorder managed care program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children
- Pay for Performance for adult and children preventive services and continuity of care through a Dental Home

County Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contract and demographic information

Managed Care

Managed Care Enrollment

By January 2021, DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries and by January 2023 requiring all dual beneficiaries, statewide to be enrolled mandatorily in a managed care plan, with the exception of those for whom managed care enrollment does not make sense due to limited scope of benefits or limited time enrolled. This will eliminate variation of managed care enrollment practices that currently vary by aid code, population, or geographical location.

Standardize Managed Care Benefit

By January 2021, DHCS proposes to standardize managed care plans benefits, so that all Medi-Cal managed care plans provide the same benefit package. Some of the most significant changes are the carving-in of institutional long-term care and major organ transplants into managed care statewide and, per Executive Order, the carving out of pharmacy.

Transition to Statewide Managed Long-Term Services and Supports

In order to achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative to standardized mandatory enrollment of dual eligibles into a Medi-Cal managed care plan for Medi-Cal benefits and integration of long-term care into managed care for all Medi-Cal populations statewide. This will be done in two phases:

January 2021: The Coordinated Care Initiative proceeds as today, however Multipurpose Senior Services Programs will be carved out and all institutional long-term care services will be carved into managed care for all populations enrolled in plans around the state. DHCS will also implement the voluntary in lieu of services benefit at this time.

January 2023: Full transition of the Coordinated Care Initiative to mandatory managed care enrollment of dual eligibles into managed care in all counties/plan models. In addition, require Medi-Cal managed care plans to operate Medicare Dual-Special Needs Plans, in order to offer dual eligible members the ability to have coordinated managed care plans for both their Medi-Cal and Medicare benefits.

The purpose of these transitions and phases is to target a long-term goal of implementing managed long term services and supports (MLTSS) statewide in Medi-Cal managed care beginning in 2026 by providing enough time and incentive to develop the needed infrastructure. This will allow beneficiaries to receive needed MLTSS and home and community based services statewide through their managed care plan, instead of a variety of 1915(c) waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their subcontractors (delegated entities) to be National Committee for Quality Assurance (NCQA) accredited by 2025. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.

Annual Medi-Cal Health Plan Open Enrollment

Effective for plan enrollment as of January 1, 2022, DHCS proposes to implement an Annual Health Plan Open Enrollment process for all managed care plan enrollees. Enrollees would generally only be allowed to change their managed care plan during the Annual Health Plan Open Enrollment period which is consistent with health care industry practice. The Annual Health Plan Open Enrollment period would first begin in November 2021. However in recognition of the concerns previously raised by stakeholders, DHCS has developed this proposal to include a consumer-friendly exemption process that will allow members who have a real need to change plans mid-year to do so in a streamlined way. Enrollment into Medi-Cal coverage would still be allowed throughout the year. This proposal provides the stability required to do effective care and case management of the plan members, while still allowing a simplified process to allow a plan change when it is needed.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model, this also coincides with a shift of the rating period from the state fiscal year to the calendar year beginning in 2020. The proposal to move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with goal of allowing DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates will allow cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging rather than just the experience of plans within the county. This change is fundamental to the ability of DHCS to implement the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps forward to invest in and improve access to mental health and substance use disorder services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS, and we recognize that the full needs of the Medi-Cal population are not being met, particularly with respect to improving services and access for children and other vulnerable populations. In order to achieve true reform, DHCS believes that an important first step is undergoing behavioral health payment reform, where DHCS will

transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. Such a shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation and engage in value-based payment arrangements with their health plan partners in order to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to further build a high quality continuum of care for mental health and substance use disorder services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to modify the medical necessity criteria in order to align with state/federal requirements and more clearly delineate and standardize the benefit statewide.

Administrative Behavioral Health Integration Statewide

Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit from integrated treatment. The State provides Medi-Cal covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, which makes it difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in mental health and substance use disorder managed care are subject to two separate annual quality assessments, two separate post payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, counties providing integrated treatment to a Medi-Cal beneficiary must document the substance use disorder service separately from the specialty mental health service. The purpose of this proposal is to make necessary state and county changes that would provide substance use disorder and specialty mental health services through one delivery system.

Behavioral Health Regional Contracting

DHCS recognizes that some counties have resource limitations often due simply to their size and the number of beneficiaries residing in their county. Therefore, DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources

should consider opportunities for regional partnership. Furthermore, DHCS is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder fee-for-service might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

DHCS proposes to incorporate the Drug Medi-Cal Organized Delivery System (also known as substance use disorder managed care) into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. DHCS also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewideness. Finally, DHCS is exploring opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

Dental

The Department has set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. In order to progress towards achieving that goal, and based on our lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide:

- Add new Dental Benefits based on the outcomes and successes from the Dental Transformation Initiative that will provide better care and align with national dental care standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high risk and institutional populations; and
- Continue and expand Pay for Performance Initiatives initiated under the Dental Transformation Initiative that reward increasing the use of preventive services and establishing/maintaining continuity of care through a Dental Home. These expanded initiatives would be available statewide for children and adult enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office as identified in a recent audit. This proposal will also ensure that DHCS is compliant with federal and State requirements. These enhancement will be done in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 child beneficiaries. The State delegates certain responsibilities for these high-risk children to California's 58 counties. The State needs to enhance the oversight of counties to ensure they comply with legislation, regulations, and State issued guidance. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the State, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable State and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

For more detailed descriptions of the CalAIM proposals please refer to the full CalAIM document located on CalAIM page of the DHCS website.

Advancing Key Priorities

These reforms are interdependent and build off one another; without one, the others are neither possible or powerful.

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other. These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value based and integrated delivery of care are significantly harder and potentially impossible to achieve. These fundamental financing changes themselves would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Therefore, carving out prescription drugs from managed care (Medi-Cal Rx) and the other carve-in/carve-outs detailed in the Medi-Cal managed care proposals are necessary and serve as the foundation for DHCS to institute the concepts around not only regional rate setting, but also nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the

possibility of future full integration pilots). The Medi-Cal program has evolved over the multiple decades since inception and has relied upon ever-increasing system and fiscal complexity in order to operate and serve the Californians who rely upon it. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be the most effective with respect to the funding utilized to most efficiently operate the program.

Furthermore, CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission. Furthermore, CalAIM will advance a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for kids, proliferating the use of value-based payments across our system, including in behavioral health and long-term care. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services including specialty mental health and substance use disorder services, Medi-Cal eligibility, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if enacted and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal. CalAIM proposes enhanced care management and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries, through a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how Californians (adults and children) will access specialty mental health and substance use disorder services. It aligns the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, eligibility for, and access to integrated behavioral health care.

Vulnerable Children: CalAIM would provide access to enhanced care management for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier,

comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

Justice Involved: The Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. These efforts will support scaling of diversion and reentry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for felons incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services would allow the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and should be a critical component on the State's Master Plan on Aging.

From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. In addition, given that California has significant learnings from our past 1115 Waivers, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with new federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

The proposal outlines all elements of the Medi-Cal 2020 waiver and how they will be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or abilities to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes under this federal authority approach. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85%

of all Medi-Cal beneficiaries receive care, to be brought into the main fold of managed care. We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost effectiveness, of the Medi-Cal/Medicaid program.

CalAIM Stakeholder Engagement

DHCS' intention in the release of these proposals is to garner important input from the many key stakeholders and partners that help us to improve upon these concepts and align them with the expertise and experience of our partners. As previously outlined, DHCS will be undertaking a significant stakeholder engagement effort that begins with the release of this document and continues through the CalAIM workgroups scheduled for November through February, the Stakeholder Advisory Committee (SAC) and Behavioral Health SAC meetings, Medi-Cal Health Advisory Panel (MCHAP) and other convenings. We recognize that CalAIM contains many significant proposals and changes to the Medi-Cal program, aimed at ultimately improving the beneficiary experience and outcomes. However, these represent DHCS' initial proposals and thinking and we look forward to working to refine and modify these proposals relying on the expertise of our stakeholder partners through this engagement process. DHCS plans to finalize all proposals for submission to CMS in the May to July period of 2020 based on the input we will receive from our partners through this process, but also dependent on the funding availability through the state budget process

Conclusion

CalAIM is an ambitious but necessary proposal to positively impact our beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.

- Creates a fundamental shift in how Californians (adults and children) will access mental health and substance use disorder services including administration of, eligibility for, and access to integrated behavioral health care.

- Provides access to enhanced care management for medically complex children and adults to ensure they get their physical, behavioral, developmental and oral health needs met.

- Builds capacity in clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail.

- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and will be a critical component on the State's Master Plan on Aging.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
27. Consider Authorizing a Grant Agreement with the County of Orange for Medical Respite Care

Contact
Tracy Hitzeman, Executive Director, Medical Management, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:
    a. Enter into a Grant Agreement with the County of Orange to fund the County's Post Whole Person Care Medical Respite Program in the amount of $250,000, effective June 1, 2020; and
    b. Amend the Coordination and Provision of Public Health Care Services Contract with the County of Orange to reflect the termination of CalOptima's Medical Respite program effective June 1, 2020.

Background/Discussion
Whole Person Care (WPC) is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home. WPC, including recuperative care, is administer by the Orange County Health Care Agency (OCHCA).

As part of evaluating the progress of the WPC pilot program, it was identified though discussions with OCHCA staff that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy, do not qualify for transition to inpatient stay or nursing facility care, and are believed to benefit from medical respite care beyond the 90 days of available recuperative care. Originally, the County anticipated that approximately two members per month would meet these criteria in order to receive medical respite care.

On April 4, 2019, the CalOptima Board of Directors (Board) established a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the OCHCA WPC pilot. The Board authorized reimbursement of the full medical respite stay at an amount of up to $120 per day for all bed days beyond the days available through the WPC Pilot Recuperative Care Program, not to exceed a cumulative grand total of $250,000, and authorized staff to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services.

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The Medical Respite Program was intended to provide support to CalOptima members experiencing homelessness who (1.) had received WPC recuperative care for the ninety (90) day maximum authorized under the WPC program, (2.) do not meet criteria for inpatient stay or nursing facility placement, (3.) lack a stable living situation, and (4.) whose medical condition(s) necessitate continued services to support the provision of medical treatment and care coordination. CalOptima and County WPC staff collaborated in development of the proposed Medical Respite Program, leveraging the existing WPC infrastructure.

In response to the approval of the Medical Respite Program, CalOptima and County staff amended the Coordination and Provision of Public Health Care Services contract ("County Contract") between the organizations to include Medical Respite services. To date, the Medical Respite Program has not billed for any of the original $250,000 in Board-approved funding. County and CalOptima staff have concluded that it would be more efficient for the County to directly operate the post-WPC Respite Care program, and doing so would allow the County to expand the program and contract with providers as it determines appropriate and consistent with the Grant Agreement. As a result, Staff is recommending that the CalOptima Medical Respite program be terminated and such termination be memorialized by an amendment to the County Contract, effective June 1, 2020. The County's Medi-Cal Respite Program would be funded in the amount of $250,000 through a new Grant Agreement that allows the County to operate and pay for the Medical Respite program directly and without the day-to-day involvement of CalOptima. Grant funds may be applied towards medical respite services already provided to CalOptima Medi-Cal members but not yet billed as such services had been contemplated and were provided under the prior arrangement. The Grant Agreement would include reporting and audit provisions to allow CalOptima to ensure that the funds are used as intended.

Fiscal Impact

The recommended actions to enter into a Grant Agreement with the County of Orange, and to remove the Medical Respite Program from the Coordination and Provision of Public Health Care Services contract has no fiscal impact to CalOptima's operating budget. Pursuant to the Board action taken on April 4, 2019, a reallocation of Intergovernmental Transfer (IGT) 6/7 funds in the amount of $250,000 funded the CalOptima Medical Respite Program. With approval of the recommended actions, CalOptima will allocate these funds to the County Grant Agreement.

Rationale for Recommendation

CalOptima staff recommends the transition of the post-WPC Medical Respite program from CalOptima to the County, which includes approval of a new Grant Agreement with the County for the Medical Respite Program with funding in the amount of $250,000 and an amendment of the County Contract to terminate the existing CalOptima Medical Respite program. Staff believes that this approach is the most effective and efficient way to provide for these Medical Respite services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by the Recommended Action
2. CalOptima Board Action dated April 4, 2019, Consider Authorizing Establishment of a Post Whole Person Care Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

/s/ Richard Sanchez — *05/27/2020*

Authorized Signature — **Date**

Attachment to the June 4, 2020 Board of Directors Meeting– Agenda Item 27

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Orange County Health Care Agency	405 W 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Contacts

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate;
2. Authorize reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program.

Background

The WPC is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. 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. DHCS approved use of IGT 6 and IGT 7 funds to support programs addressing the following areas: Community health investments which may include programs addressing opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by a member health needs assessment. At the August 2, 2018 Board of Directors meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. A grant allocation of up to $10 million was approved from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for homeless CalOptima members under the WPC

pilot. The funds are currently designated for funding 50 percent of medically justified recuperative care bed days up to a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available. The CalOptima Board of Directors also approved an amendment of the agreement with the County of Orange to include indemnity language and allowing for use of the allocated funds for recuperative care services under the County's WPC Pilot program for qualifying homeless CalOptima members.

Discussion

Since 2016, the OCHCA has collaborated with CalOptima and other community-based organizations, community clinics, hospitals, and county agencies to design and implement the WPC Pilot program. The recuperative care element of the WPC pilot is a critical component of the program. During calendar year 2018, the WPC recuperative care program provided services to 487 unique CalOptima members experiencing homelessness. Between August and December 2018, the average length of stay for these individuals was 34 days, at a cost of $705,250.

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy but do not qualify for transition to skilled nursing care, may benefit from medical respite care beyond the 90 days of recuperative care.

To address this concern, CalOptima staff, with the support of OCHCA WPC staff, and consistent with the approved IGT 6/7 funding categories, is proposing to develop a Medical Respite Program for CalOptima members who need extended medical care beyond the 90 days as provided under the current scope of the WPC Pilot to achieve and maintain medical stability. Staff is in the process of developing policies related to the proposed medical respite program, the purpose of which is to provide short-term residential care to allow individuals with unstable living situations the opportunity to rest in a safe and clean environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite care seeks to improve transitional care for the population and to aid in ending the cycle of homelessness while also gaining stability with case management relationships and programs. As appropriate, staff will seek state approval of this new Medical Respite Program, which is intended to support homeless CalOptima members as they recover and attain medical stability, or in the case of members in hospice, to receive services in a stable environment care. The additional time beyond the days available through the County's WPC program is intended to reduce inappropriate and/or avoidable utilization of hospital Emergency Departments, inpatient admissions and re-admissions.

CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis and will need approval by County WPC staff, County Medical Safety Net (MSN) program nurses and CalOptima to be eligible for the Medical Respite Program. Regular reviews and updates will be conducted by the MSN program nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical

stability and steps to move to a skilled nursing facility (SNF), if appropriate. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. CalOptima will monitor utilization and member outcomes.

In addition, staff is seeking authority to reallocate $250,000 out of the $10 million the Board allocated to OCHCA WPC program for recuperative care to fund the Medical Respite Program. In other words, no new funding is being proposed. Instead, the recommendation for authority is to redirect dollars previously committed for recuperative care for homeless CalOptima members in coordination with the County's WPC program. Staff is also seeking authority to provide the OCHCA with reimbursement for the full cost of the Medical Respite Program stay at $120 per day, for all bed days beyond the WPC Pilot recuperative care program, not to exceed the requested reallocation amount of $250,000. The OCHCA supports the recommended actions and plans to continue to invoice CalOptima for members in the Medical Respite Program via a similar process such as the already established invoicing process for recuperative care. The funds will be available through the end of the WPC Pilot or until the funds are exhausted, whichever comes first.

Fiscal Impact
The recommended actions to authorize the creation of a Medical Respite Program for CalOptima members and to authorize a reallocation of $250,000 from the $10 million IGT allocation to Orange County Health Care Agency (OCHCA) for recuperative care services, previously approved by the Board on August 2, 2018, 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. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
2. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. 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, is committed to working 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 for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader *9/25/2015*
Authorized Signature **Date**

CalOptima
A Public Agency
Better. Together.

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

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IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken 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:

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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**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

10. Consider Authorization of Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2020–2021 Capital Budget

Contacts

Ladan Khamseh, Chief Operating Officer, 714-246-8866
David O'Brien, Director Information Services, 714-246-1269

Recommended Action

Recommend authorizing reallocation of budgeted but unused funds in the amount of up to $430,000 from the Network – Wireless System Upgrade project to fund the Telephony – Upgrade Contact Center project through June 30, 2021

Background/Discussion

CalOptima's telephony infrastructure utilizes a mixed environment of Avaya and Nortel systems for the Private Branch Exchange (PBX) and Call Center services. As of August 2020, much of CalOptima's telephony hardware and software will be at the end of manufacturer support. Manufacturers' end-of-support designation greatly reduces the level of support we receive in the event of an issue. Additionally, with many of the hardware components more than 10 years old, the age of the equipment has passed its useful and expected life, increasing the likelihood of failure.

The telephony and Call Center infrastructure systems are critical to CalOptima's ability to communicate internally and, most importantly, communicate externally with our members and provider partners. A service disruption or extended outage of these systems would greatly impact our ability to communicate with members and providers. This necessary upgrade was slated in two stages due to current fiscal year (FY) budget constraints, with the first portion budgeted and approved in FY 2020, for $50,000 to improve the "call flow" configurations within our Avaya call center software. The remainder of the project was slated for FY2021.

Additionally, in FY 2020, CalOptima's IS Department budgeted $430,000 as part of an approved project to upgrade the wireless network infrastructure within the 505 building. The existing infrastructure is old, having been implemented during the move to the 505 building nearly 10 years earlier. An upgrade of these systems would provide faster and more stable wireless services throughout the facility. However, due to COVID-19 precautions, only approximately 10% of the CalOptima workforce is presently working at the 505 building. This upgrade, while needed, is not as critical to our ability to support our members and providers.

To ensure that CalOptima can provide a stable and secure telephony services for our personnel, members and provider partners, management recommends reprioritizing these two initiatives to address the completion of the telephony upgrade earlier, and defer the upgrade of the wireless infrastructure to FY 2021-22. The Telephony - Upgrade Contact Center project is included in the FY 2020-21 Capital Budget that was approved by the Board on June 4, 2020, in the amount of $50,000 (i.e., $25,000 in Hardware and $25,000 in Software). Management proposes to reallocate $430,000 from the Network – Wireless System

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Upgrade project to fund the Telephony – Upgrade Contact Center project. Specifically, the following amounts would be reallocated from Network – Wireless System Upgrade – Hardware:

- Up to $15,000 to Telephony --Upgrade Contact Center – Hardware;
- Up to $300,000 to Telephony –Upgrade Contact Center – Software; and
- Up to $115,000 to Telephony – Upgrade Contact Center – Professional Fees**.**

This will ensure adequate support and response times from our vendors as necessary. Assuming the Board approves the recommended reallocation, Staff plans to include the network wireless upgrade in the FY 2021-22 Capital Budget.

CalOptima will also be able to take advantage of the 2020 discounted pricing from Avaya and our systems integrator. Additionally, with a supported infrastructure, our annual operational maintenance cost, starting in FY 2022, is expected to be reduced by 31%.

Fiscal Impact
The fiscal impact for the recommended action is budget neutral. Unspent budgeted funds from the Network – Wireless System Upgrade project included in the Board-approved FY 2020-21 Capital Budget will fund the total cost of up to $430,000 for this action.

Rationale for Recommendation
To ensure that CalOptima's Telephony infrastructure, including the call centers, continues to function properly and reliably to support the organization, members and providers.

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

Attachment
1. Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Avaya Inc.	2605 Meridian Parkway, STE 200	Durham	NC	27713
Dell	One Dell Way	Round Rock	TX	78682
Intelli-Flex/Telanet	17315 Studebaker Rd. Ste 332	Cerritos	CA	90703
Microsoft	One Microsoft Way	Redmond	WA	98052
Nth Generation	17055 Camino San Bernardo	San Diego	CA	92127
CenturyLink / Lumen	19000 MacArthur Bl, Ste. 400	Irvine	CA	92612

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

11. Consider Ratifying Contract with Chapman Consulting for Consulting Services related to the 2020-2022 Strategic Plan

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Candice Gomez, Executive Director, Program Implementation, (714) 246-8849

Recommended Action

Ratify contract with Chapman Consulting for consulting services related to the 2020-2022 Strategic Plan.

Background

On December 5, 2019, the CalOptima Board of Directors adopted the 2020–2022 Strategic Plan. CalOptima previously engaged Chapman Consulting to provide consulting services related to strategic plan development activities. Chapman Consulting was selected through a competitive Request for Proposal process and approved by the Board on April 4, 2019. Chapman Consulting's work to support the development of the current strategic plan included reviewing CalOptima's previous strategic plans and conducting interviews with Board members, CalOptima Advisory Committee members, health networks, and executive staff. It also included facilitation of a full day Board planning session and development of an Environmental Scan. These efforts were utilized to develop the substance of the current strategic plan.

Information regarding the strategic plan is provided as new Board members are appointed and seated. Considering changes in the Board's composition, staff received direction at the October 2020 Board meeting to assist the Board in reviewing the current strategic plan in order to better understand how the plan was developed, discuss changes to the current health care and regulatory environment due to the COVID-19 pandemic, and consider additional guidance regarding strategic direction. Based on this direction, a 2020-2022 Strategic Plan review session was scheduled for November 16, 2020. However, due to concerns about the COVID-19 pandemic and the rising number of cases, a decision was made to postpone the Strategic Plan review session until a later date.

Discussion

For continuity between the original planning process and the soon to be rescheduled Strategic Plan review session, staff re-engaged Chapman Consulting effective November 4, 2020 through June 30, 2021. For this engagement, services to be provided by Chapman Consulting include, but are not limited to, planning beginning in October and facilitating the Strategic Plan review session of the currently approved 2020-2022 Strategic Plan, providing a look-back and an update on recent changes impacting the environmental scan, recording and developing final materials based on feedback received from Board members, and supporting CalOptima staff with the implementation of any changes or updates. The CalOptima Fiscal Year (FY) 2020-21 Operating Budget included allocations towards consultant services of which $20,000 will be used to fund the contract through June 30, 2021. Staff requests that the Board ratify the contract with Chapman Consulting.

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Fiscal Impact

The recommended action to ratify the contract with Chapman Consulting for the 2020-2022 CalOptima Strategic Plan has no additional fiscal impact. A total of $50,000 for Consulting services related to Support for Implementation of the Strategic Plan, Initiatives Aligned with the Strategic Plan, and Other Programs is included in the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020, and funds for this engagement will be drawn from this budget category.

Rationale for Recommendation

Contracting with Chapman Consulting for consulting services related to the 2020-2022 Strategic Plan review session provides continuity between the original planning process and continued discussion of the organization's strategic direction.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by This Recommended Board Action
2. Board Action dated April 4, 2019: Consider Authorizing Contract with Vendor for Consulting Services Related to Strategic Plan 2020-2022
3. Board Action dated December 5, 2019: Consider Approval of CalOptima's 2020-2022 Strategic Plan
4. Board Informational Item dated October 1, 2020: CalOptima 2017-2019 Strategic Plan Closure and 2020-2022 Strategic Plan Update
5. CalOptima's 2020-2022 Strategic Plan

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Chapman Consulting	1133 Los Robles St.	Davis	CA	95618

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Authorizing Contract with Vendor for Consulting Services Related to CalOptima's Strategic Plan 2020-2022

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions

1. Approve recommended consultant Chapman Consulting for consulting services for the CalOptima Strategic Plan 2020-2022 activities;
2. Authorize the Chief Executive Officer (CEO) with the assistance of Legal Counsel to enter into an agreement with the recommended consulting organization; and
3. In the event CalOptima and Chapman Consulting are unable to reach agreeable contract terms within thirty (30) days, authorize the CEO, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Pacific Health Consulting Group for consulting services for the CalOptima Strategic Plan 2020-2022 activities.

Background

At the February 7, 2019, CalOptima Board of Directors meeting, staff presented an Informational Item on the Year 2 Progress Report of CalOptima's 2017-2019 Strategic Plan and a Planning Process for CalOptima's 2020-2022 Strategic Plan.

The 2017-2019 Strategic Plan will expire at the end of the 2019 calendar year. Following CalOptima's competitive bidding process in accordance with CalOptima Policy GA.5002: Purchasing, staff initiated a Request for Proposal (RFP) on January 9, 2019, for consulting services for the CalOptima 2020-2022 Strategic Plan activities.

Discussion

On February 20, 2019, CalOptima received seven (7) RFP responses for strategic planning consulting services from the following organizations:

- Chapman Consulting
- Curt Pringle & Associates
- Medecision, Inc.
- Milliman, Inc.
- Optum
- Pacific Health Consulting Group
- Spring Street Exchange

The submitted proposals were reviewed by an evaluation team consisting of representatives from Strategic Development, Government Affairs, Program Implementation, Health Network Management, Vendor Management and Customer Service. Additionally, the top two vendors (Chapman Consulting and Pacific Health Consulting Group) were invited for an interview.

The recommended consultant will help facilitate several activities, including, but not limited to: review of CalOptima's previous Strategic Plan and specified data; interviews and planning sessions with members of CalOptima's Board of Directors executive level staff, and CalOptima Advisory Committees; engagement with key stakeholders; develop a draft of the Strategic Plan; and present a final plan to the Board of Directors.

Vendor	Final Weighted Score
Chapman Consulting	19.15
Pacific Health Consulting Group	11.25

Based on the final weighted scores, staff recommends contracting with Chapman Consulting for consulting services for the CalOptima Strategic Plan 2020-2022 activities in an amount not to exceed $81,950.

Chapman Consulting, LLC was established in January of 2018 as an independent consulting firm. Prior to establishing an independent consulting firm, the principal of Chapman Consulting, Ms. Athena Chapman, previously worked with the California Association of Health Plans (CAHP) as the Vice President of State programs. Ms. Chapman also worked with the Center for Medicare & Medicaid Services (CMS) as well as at the Department of Health Care Services (DHCS). Chapman Consulting has expertise in health care policy, delivery, administration, and financing and specific expertise in the Medi-Cal program. The proposed consultant has worked with health plans that provide coverage in the commercial market, the Covered California healthcare exchange and Medicaid and has a strong track record of building relationships between the government, providers, purchasers, vendors, and other stakeholders. Chapman Consulting can take complex health policy issues and provide succinct and relevant policy analysis and program recommendations. The proposed consultant also has extensive experience with meeting facilitation and has successfully developed several strategic and project-based plans for health care organizations. Chapman Consulting provides strategic planning, meeting facilitation, organizational support, and regulatory and statutory analysis, to a variety of health care related organizations. Chapman Consulting recently worked with the Coalition of Orange County Community Health Centers.

In the event CalOptima cannot reach agreeable contract terms with Chapman Consulting within thirty (30) days of CalOptima providing a response to any proposed contract change, staff recommends the Board of Directors authorize a similar process with Pacific Health Consulting Group and attempt to reach agreement on contract terms within a thirty (30) day timeframe.

Upon completion of the contracted work, the consulting organization will provide CalOptima and the Board of Directors with an updated organizational Strategic Plan for 2020-2022.

Fiscal Impact

The recommended action to authorize an agreement for consulting services for the CalOptima Strategic Plan 2020-2022 activities has no additional fiscal impact for the current fiscal year. The CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018 included $50,000 for this purpose. Management will include the remaining $31,950 in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

Development of the proposed Strategic Plan is consistent with direction provided by the Board of Directors at the February 7, 2019, meeting.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Strategic Plan Scope of Work
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

Scope of Work
CalOptima
Strategic Planning Development

Anticipated Consultant Outcomes
To develop and approve the 2020-2022 Strategic Plan in collaboration with CalOptima Board of Directors, Executive Leadership and Community stakeholders.

The CONTRACTOR shall provide the following tasks and activities. Please note the dates provided are estimated dates and are for planning purposes only.

1. **Project Initiation** — April 2019
   - Define key deliverables
   - Identify key contacts
   - Establish detailed work plan and milestones

2. **Discovery** — May-June 2019
   - Review previous strategic plans
   - Interview CalOptima Board of Directors
   - Interview CalOptima Executive team and other key staff
   - Identify strategic priority areas
   - Identify over-arching themes and outcomes
   - Identify key stakeholders

3. **Planning and Design** — June-July 2019
   - Consolidate feedback received during interview sessions
   - Facilitate planning session with CalOptima Board of Directors
   - Establish stakeholder engagement plan

4. **Stakeholder Engagement** — July-August 2019
   - Engage CalOptima advisory committees
     - Member Advisory Committee
     - Provider Advisory Committee
     - OneCare Connect Member Advisory Committee
     - Whole Child Model Family Advisory Committee
   - Engage and interview other key stakeholders/key informants
   - Consolidate feedback

5. **Strategic Plan Development** — August -September 2019
   - Analyze feedback
   - Develop draft strategic plan

6. **Finalize Strategic Plan** — September-December 2019
   - Finalize draft
   - Review draft with Board of Directors
   - Incorporate feedback
   - Review Final with Board of Directors

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Chapman Consulting	1133 Los Robles St.	Davis	CA	95618
Pacific Health Consulting Group	72 Oak Knoll Ave.	San Anselmo	CA	94960
Curt Pringle & Associates	1801 E. Katella Ave., Suite 1002	Anaheim	CA	92805
Medecision, Inc.	550 E. Swedesford Road, Suite 220	Wayne	PA	19087
Milliman, Inc.	1301 Fifth Ave., Suite 3800	Seattle	WA	98101
Optum	11000 Optum Circle	Eden Prairie	MN	55344
Spring Street Exchange	26 Grant St.	Lexington	MA	02420

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Approval of CalOptima's 2020-2022 Strategic Plan

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
1. Adopt CalOptima's 2020-2022 Strategic Plan; and
2. Direct the Chief Executive Officer (CEO) to implement the strategic plan and provide regular progress reports to the Board of Directors over the course of its implementation.

Background/Discussion
CalOptima's 2017-2019 Strategic Plan will expire at the end of the 2019 calendar year. At the April 4, 2019 meeting, the Board approved a contract with Chapman Consulting to provide consulting services related to the CalOptima 2020-2022 Strategic Plan development activities.

Chapman Consulting's work to support the development of the 2020-2022 Strategic Plan included reviewing the current and previous strategic plans and conducting interviews with members of the CalOptima Board of Directors, chairs and co-chairs of the CalOptima Advisory Committees (Member Advisory Committee, OneCare Connect Member Advisory Committee, Whole-Child Model Family Advisory Committee and Provider Advisory Committee) and Executive staff. It also included facilitation of a full-day Board of Directors planning session and development of an Environmental Scan. These efforts were utilized to develop the substance of the draft strategic plan in accordance with Chapman Consulting's scope of work.

While developing the draft strategic plan, Chapman Consulting also facilitated a discussion at a joint meeting of CalOptima's Advisory Committees, as well as at a meeting with CalOptima's contracted Health Networks. The feedback received at those meetings was incorporated into the draft plan.

As a result of the efforts and feedback received, the following priority areas were identified and supported:

- Innovate and Be Proactive
- Expand CalOptima's Member Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

On November 7, 2019, an Information Item, including the draft Strategic Plan, was presented during the Board of Directors meeting. Staff is now recommending final approval of the 2020-2022 Strategic Plan. Upon approval by the Board of Directors, staff will finalize the graphic design for publication of the 2020-2022 Strategic Plan consistent with CalOptima branding guidelines.

The priority areas will support planning and development of CalOptima programs and initiatives over the course of the next few calendar years. These will include, for example, development of the

expenditure plan for intergovernmental transfer funds expected during Fiscal Year 2020 and upcoming quality initiatives. Staff will begin to seek stakeholder input and return to your Board for approval of the expenditure plans, as appropriate.

Fiscal Impact

The recommended action to authorize CalOptima's 2020-2022 Strategic Plan is a budgeted item. The CalOptima Fiscal Year 2019-20 Operating Budget, approved by the CalOptima Board of Directors on June 6, 2019, included $50,000 to fund this action.

Rationale for Recommendation

Development of the proposed Strategic Plan is consistent with the direction provided by the Board of Directors to support planning and development of CalOptima programs and initiatives during 2020-2022.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima's 2020-2022 Strategic Plan
2. Board Action dated April 4, 2019 Consider Authorizing Contract with Vendor for Consulting Services Related to Strategic Plan 20202-2022
3. Board Information Item dated November 7, 2019 including the CalOptima Draft Strategic Plan 2020-2022 dated October 28, 2019 and Final CalOptima 2020- 2022 Strategic Plan Environmental Scan dated September 19, 2019

/s/ Michael Schrader — *11/26/2019*

Authorized Signature — **Date**

CHAPMAN
CONSULTING

CalOptima Strategic Plan 2020-2022

DOCUMENT PENDING GRAPHIC DESIGN

BY:
ATHENA CHAPMAN & CAROLINE DAVIS
NOVEMBER 15, 2019

Message from 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

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

Products

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 benefits. 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 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 September 30, 2019, CalOptima has approximately 730,000 enrollees[i]: **(to be converted to pie chart in final version)**

- Medi-Cal: 711,968
- OneCare Connect (Cal MediConnect): 14,186
- OneCare: 1,564
- PACE: 356

Health Insurance Coverage in Orange County

CalOptima covers over 20% of Orange County residents.[ii]

Current Health Insurance Coverage Type	Orange County
Uninsured	6.7%
Medicare & Medicaid (Dual Eligibles)	3.0%
Medicare	11.2%
Medicaid	19.1%
Employment-based	51.8%
Privately Purchased	7.5%
Other Public Coverage	0.7%

CalOptima Profile[iii]

Members by Age (to be converted to pie chart in final version):

- Age 0-18 40%
- Age 19-64 48%
- Age 65+ 12%

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 cost-effective quality health care services in a compassionate manner.

Provider Network Composition:

CalOptima has a strong provider network, which includes the contracted health networks, to serve our members:

- 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 alternate 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.

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 last three years, and this is expected to continue for the foreseeable future. The Centers for Medicare and 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 Newsom in November 2018. 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 Medicare Advantage 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 andCMC transitions.

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 multi-faceted approach is necessary to respond to the needs of County residents experiencing homelessness. CalOptima has committed $100 million to fund 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 care in the field and increased preventive and primary care at shelters, establishing an internal homeless response team, 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 pre-paying 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.

Strategic Plan Development Process

To develop our 2020-2022 Strategic Plan, we gathered input from a wide range of CalOptima stakeholders:

- CalOptima's Board members, Executive Team and Advisory Committee leaders were interviewed to gather feedback about the current strategic plan as well as the issues and challenges facing the health plan over the next three years.
- 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.
- 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.
- The draft 2020-2022 Strategic Plan was presented to the Board on **November 7**, 2019 for review and discussion.
- The final 2020-2022 Strategic Plan was adopted by the Board on **Month ##,** 2019.

Strategic Priorities & Objectives

Our members are the essential focus of the Priorities and Objectives for the 2020-2022 Strategic Plan and are supported by the programs and services provided by CalOptima.

Innovate & 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 Provided 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

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[i] Source: CalOptima Fast Facts, Available at: https://www.caloptima.org/en/About/AboutCalOptima/FastFacts.aspx

[ii] Source: CHIS, 2017 California Health Interview Survey data. Available at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Authorizing Contract with Vendor for Consulting Services Related to CalOptima's Strategic Plan 2020-2022

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions

1. Approve recommended consultant Chapman Consulting for consulting services for the CalOptima Strategic Plan 2020-2022 activities;
2. Authorize the Chief Executive Officer (CEO) with the assistance of Legal Counsel to enter into an agreement with the recommended consulting organization; and
3. In the event CalOptima and Chapman Consulting are unable to reach agreeable contract terms within thirty (30) days, authorize the CEO, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Pacific Health Consulting Group for consulting services for the CalOptima Strategic Plan 2020-2022 activities.

Background

At the February 7, 2019, CalOptima Board of Directors meeting, staff presented an Informational Item on the Year 2 Progress Report of CalOptima's 2017-2019 Strategic Plan and a Planning Process for CalOptima's 2020-2022 Strategic Plan.

The 2017-2019 Strategic Plan will expire at the end of the 2019 calendar year. Following CalOptima's competitive bidding process in accordance with CalOptima Policy GA.5002: Purchasing, staff initiated a Request for Proposal (RFP) on January 9, 2019, for consulting services for the CalOptima 2020-2022 Strategic Plan activities.

Discussion

On February 20, 2019, CalOptima received seven (7) RFP responses for strategic planning consulting services from the following organizations:

- Chapman Consulting
- Curt Pringle & Associates
- Medecision, Inc.
- Milliman, Inc.
- Optum
- Pacific Health Consulting Group
- Spring Street Exchange

The submitted proposals were reviewed by an evaluation team consisting of representatives from Strategic Development, Government Affairs, Program Implementation, Health Network Management, Vendor Management and Customer Service. Additionally, the top two vendors (Chapman Consulting and Pacific Health Consulting Group) were invited for an interview.

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The recommended consultant will help facilitate several activities, including, but not limited to: review of CalOptima's previous Strategic Plan and specified data; interviews and planning sessions with members of CalOptima's Board of Directors executive level staff, and CalOptima Advisory Committees; engagement with key stakeholders; develop a draft of the Strategic Plan; and present a final plan to the Board of Directors.

Vendor	Final Weighted Score
Chapman Consulting	19.15
Pacific Health Consulting Group	11.25

Based on the final weighted scores, staff recommends contracting with Chapman Consulting for consulting services for the CalOptima Strategic Plan 2020-2022 activities in an amount not to exceed $81,950.

Chapman Consulting, LLC was established in January of 2018 as an independent consulting firm. Prior to establishing an independent consulting firm, the principal of Chapman Consulting, Ms. Athena Chapman, previously worked with the California Association of Health Plans (CAHP) as the Vice President of State programs. Ms. Chapman also worked with the Center for Medicare & Medicaid Services (CMS) as well as at the Department of Health Care Services (DHCS). Chapman Consulting has expertise in health care policy, delivery, administration, and financing and specific expertise in the Medi-Cal program. The proposed consultant has worked with health plans that provide coverage in the commercial market, the Covered California healthcare exchange and Medicaid and has a strong track record of building relationships between the government, providers, purchasers, vendors, and other stakeholders. Chapman Consulting can take complex health policy issues and provide succinct and relevant policy analysis and program recommendations. The proposed consultant also has extensive experience with meeting facilitation and has successfully developed several strategic and project-based plans for health care organizations. Chapman Consulting provides strategic planning, meeting facilitation, organizational support, and regulatory and statutory analysis, to a variety of health care related organizations. Chapman Consulting recently worked with the Coalition of Orange County Community Health Centers.

In the event CalOptima cannot reach agreeable contract terms with Chapman Consulting within thirty (30) days of CalOptima providing a response to any proposed contract change, staff recommends the Board of Directors authorize a similar process with Pacific Health Consulting Group and attempt to reach agreement on contract terms within a thirty (30) day timeframe.

Upon completion of the contracted work, the consulting organization will provide CalOptima and the Board of Directors with an updated organizational Strategic Plan for 2020-2022.

Fiscal Impact

The recommended action to authorize an agreement for consulting services for the CalOptima Strategic Plan 2020-2022 activities has no additional fiscal impact for the current fiscal year. The CalOptima Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018 included $50,000 for this purpose. Management will include the remaining $31,950 in the CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

Development of the proposed Strategic Plan is consistent with direction provided by the Board of Directors at the February 7, 2019, meeting.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Strategic Plan Scope of Work
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

Scope of Work
CalOptima
Strategic Planning Development

Anticipated Consultant Outcomes
To develop and approve the 2020-2022 Strategic Plan in collaboration with CalOptima Board of Directors, Executive Leadership and Community stakeholders.

The CONTRACTOR shall provide the following tasks and activities. Please note the dates provided are estimated dates and are for planning purposes only.

1. **Project Initiation** — April 2019
   - Define key deliverables
   - Identify key contacts
   - Establish detailed work plan and milestones

2. **Discovery** — May-June 2019
   - Review previous strategic plans
   - Interview CalOptima Board of Directors
   - Interview CalOptima Executive team and other key staff
   - Identify strategic priority areas
   - Identify over-arching themes and outcomes
   - Identify key stakeholders

3. **Planning and Design** — June-July 2019
   - Consolidate feedback received during interview sessions
   - Facilitate planning session with CalOptima Board of Directors
   - Establish stakeholder engagement plan

4. **Stakeholder Engagement** — July-August 2019
   - Engage CalOptima advisory committees
     - Member Advisory Committee
     - Provider Advisory Committee
     - OneCare Connect Member Advisory Committee
     - Whole Child Model Family Advisory Committee
   - Engage and interview other key stakeholders/key informants
   - Consolidate feedback

5. **Strategic Plan Development** — August -September 2019
   - Analyze feedback
   - Develop draft strategic plan

6. **Finalize Strategic Plan** — September-December 2019
   - Finalize draft
   - Review draft with Board of Directors
   - Incorporate feedback
   - Review Final with Board of Directors

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Chapman Consulting	1133 Los Robles St.	Davis	CA	95618
Pacific Health Consulting Group	72 Oak Knoll Ave.	San Anselmo	CA	94960
Curt Pringle & Associates	1801 E. Katella Ave., Suite 1002	Anaheim	CA	92805
Medecision, Inc.	550 E. Swedesford Road, Suite 220	Wayne	PA	19087
Milliman, Inc.	1301 Fifth Ave., Suite 3800	Seattle	WA	98101
Optum	11000 Optum Circle	Eden Prairie	MN	55344
Spring Street Exchange	26 Grant St.	Lexington	MA	02420

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Board of Directors Meeting
November 7, 2019

CalOptima Draft 2020-2022 Strategic Plan

Background
At the February 7, 2019, CalOptima Board of Directors (Board) meeting, staff presented an Information Item on the Year two (2) Progress Report of CalOptima's 2017-2019 Strategic Plan; the current Strategic Plan will expire at the end of the 2019 calendar year. The Information Item also included the planning process for CalOptima's 2020-2022 Strategic Plan. During the April 24, 2019 meeting, the Board approved a contract with Chapman Consulting to provide consulting services related to the CalOptima 2020-2022 Strategic Plan activities.

Discussion
Chapman Consulting performed work to support the development of the 2020-2022 Strategic Plan. Activities included reviewing the current and previous Strategic Plans, conducting Board of Directors and Executive staff interviews, facilitating a full-day Board of Directors planning session and recently also facilitating a 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), as well as a meeting with Health Network representatives, and developing an Environmental Scan. A draft of the 2020-2022 Strategic Plan and the Environmental Scan are included for review.

Next Steps
Your Board's feedback to the draft, if any, will be incorporated by Chapman Consulting. Staff expects to request approval of the CalOptima 2020-2022 Strategic Plan during the December 2019 Board meeting. The priority areas will support planning and development of programs and initiatives over the course of the next few years. These will include, for example, development of the Expenditure Plan for Intergovernmental Transfer Funds expected during Fiscal Year 2020 and upcoming Quality Initiatives; staff will begin to seek stakeholder input and then return to your Board for approval of the Expenditure Plans, as appropriate.

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CHAPMAN
CONSULTING

CalOptima Strategic Plan 2020-2022

DRAFT DOCUMENT FOR REVIEW

DOCUMENT PENDING GRAPHIC DESIGN

BY:
ATHENA CHAPMAN & CAROLINE DAVIS
OCTOBER 28, 2019

Message from CEO

CalOptima Staff to Provide

About CalOptima

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CalOptima Enrollee Profile[iii]

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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.

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- CalOptima's Board members, Executive Team and Advisory Committee leaders were interviewed to gather feedback about the current strategic plan as well as the issues and challenges facing the health plan over the next three years.
- 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.

- 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.
- The draft 2020-2022 Strategic Plan was presented to the Board on **Month ##**, 2019 for review and discussion.
- The final 2020-2022 Strategic Plan was adopted by the Board on **Month ##,** 2019.

Strategic Priorities & Objectives

Our members are the essential focus of the Priorities and Objectives for the 2020-2022 Strategic Plan and are supported by the programs and services provided by CalOptima.

Innovate & 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 Provided 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

[i] Source: CalOptima Fast Facts, Available at: https://www.caloptima.org/en/About/AboutCalOptima/FastFacts.aspx

[ii] Source: CHIS, 2017 California Health Interview Survey data. Available at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[iii] Source: CalOptima Fast Facts, Available at:
https://www.caloptima.org/en/About/AboutCalOptima/FastFacts.aspx

CHAPMAN
CONSULTING

CALOPTIMA 2020-2022 STRATEGIC PLAN

ENVIRONMENTAL SCAN

BY:
ATHENA CHAPMAN & CAROLINE DAVIS
SEPTEMBER 19, 2019

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Introduction

CalOptima's mission is "to provide members with access to quality health care services delivered in a cost-effective and compassionate manner," and the health plan's vision is "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 its members. The environment in which the health plan realizes its mission and vision is complex, reflecting the intersection of federal- and state-level priorities with local needs and goals. This memo provides an overview of the federal, state and local landscape that set the stage for the opportunities for and challenges to CalOptima's work and how that interacts with its daily operations and longer-term strategic vision.

The information from the environmental scan has been integrated with the themes and insights obtained from the interviews with CalOptima's Board of Directors, Executive Team, and Advisory Committee provides the framework for the 2020-2022 CalOptima Strategic Plan. The data in the environmental scan is as of July 2019.

CalOptima

In 1993, the Orange County Board of Supervisors created CalOptima as a County Organized Health System (COHS). Initially created to serve the Medi-Cal program, CalOptima currently offers the following four programs:

- Medi-Cal – a public-sector health insurance program that serves low-income individuals and families
- OneCare Connect (Cal MediConnect Plan) – a program that serves members eligible for both Medi-Cal and Medicare coverage (i.e., the dual-eligible population). This program combines the Medicare and Medi-Cal benefits into a single plan and offers additional benefits as well.
- OneCare – a Medicare Dual Special Needs Plan (D-SNP) for individuals who qualify for both Medicare and Medi-Cal.
- Program for All-Inclusive Care for the Elderly (PACE) – a community-based program that supports frail seniors by providing coordinated and integrated services to help them continue to live independently. PACE provides the acute and long-term care services covered by both Medicare and Medi-Cal.

As of July 2019, CalOptima has over 750,000 enrollees across the following products:

- Medi-Cal: 739,771
- OneCare Connect (Cal MediConnect): 14,257
- OneCare:1,530
- PACE: 335[i]

As a COHS plan, CalOptima is the sole Medi-Cal managed care plan in Orange County, which makes it an integral part of the safety-net. CalOptima has demonstrated it can take advantage of its unique role and have a direct impact on care delivery, cost, and quality for this population. For the five years in a row, CalOptima received recognition as the top-rated health plan in California for outstanding quality, according to the National Committee for Quality Assurance (NCQA); For 2019-2020, no other health plan

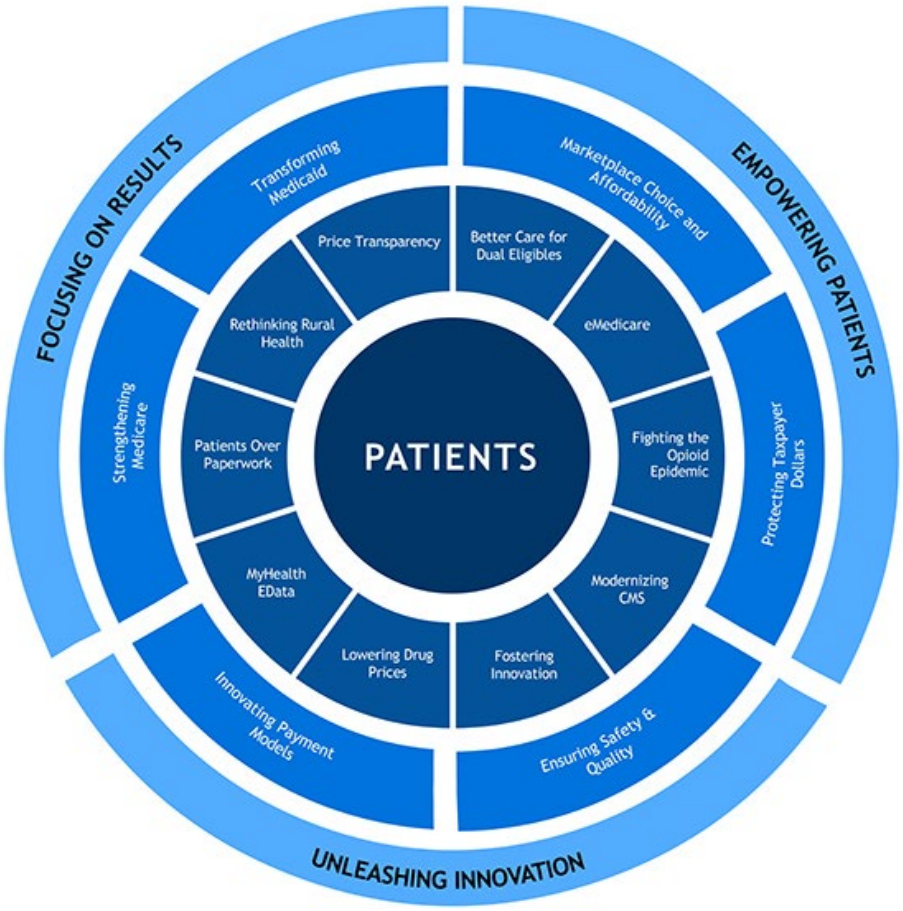
received a higher rating. CalOptima's NCQA accreditation was recently renewed at the Commendable level again.

Additionally, CalOptima has continued to explore additional lines of business and pilot programs that are in line with the needs of its community and to test new ways to deliver high-quality care for its members. CalOptima is in a strong strategic position to build on its successes and continue to explore additional ways to support its membership and local community.

Federal Landscape

For the last several years, the federal health policy landscape has been defined by uncertainty, and this will continue into the foreseeable future. This debate could be restarted depending on the outcomes of the 2020 election. Further, lawsuits seeking to repeal the ACA continue to work their way through the federal court system. The growth in the federal deficit also increases the likelihood of Congressional action to reduce Medicaid and Medicare spending, which could include converting Medicaid financing into a block grant or per capita cap structure.

The Centers for Medicare and Medicaid Services (CMS), which provides the federal funding and oversight for the Medicaid program, has established 16 strategic initiatives, which are shown below.[ii]



CMS' strategic priorities are focused on driving innovation, implementing patient-centric approaches, and demonstrating results that improve care and lower costs. These priorities can be used to help guide how CalOptima can strategically position itself and prepare to proactively work toward CMS's goals as well as provide insights into potential areas of focus at the federal level for both Medicaid and Medicare. The ability to anticipate changes at the federal level and minimize the disruption caused by the implementation of new federal requirements and initiatives will allow CalOptima to be proactive and innovative.

In separate but relevant activity, the federal Administration's recent actions related to public programs may have a negative impact on total Medicaid enrollment. A recent fact sheet from the Kaiser Family Foundation notes concerns about current immigration policy and the impacts on enrollment in public sector programs (including Medicaid) by lawfully present immigrants, citizen children immigrants, and undocumented populations.[iii] The recently-published "public charge" rule also is likely to lead to a decline in Medicaid enrollment as it expands the programs used to deem a legal immigrant a "public charge" (which can make it more difficult for an individual to gain legal permanent residency status or obtain a visa to enter the U.S.) to include Medicaid. [iv] It is expected the public charge rule will be challenged in court, but the Medicaid enrollment impacts in California may be felt more immediately than this issue can be resolved.

State Landscape

Within California, the health policy landscape is in transition with the election of Governor Newsom in November 2018. The appointment of a consumer-focused and innovative health policy team demonstrates that the Governor intends to continue to drive significant changes across the health care landscape in California. Newsom has an ambitious health care agenda that includes moving California to some form of universal coverage. Additionally, the Newsom Administration has used its healthcare platform to take several significant actions in its first six months:

- Appointment of Nadine Burke Harris, MD as the first Surgeon General for California. Surgeon General Dr. Burke Harris has a strong focus on how Adverse Childhood Experiences (ACES) and social determinants of health impact health outcomes;
- Appointment of Tom Insel as the first state Mental Health Czar with a directive to develop a blueprint to address behavioral health issues across the state;
- Release of an Executive Order on bulk pharmacy purchasing to reduce rising prescription drug costs, including the carve-out of pharmacy from the Medi-Cal managed care plans;
- Release of an Executive Order that calls for the development of a "Master Plan for Aging" by October 2020 with input from a Cabinet-Level Workgroup that will work with a Stakeholder Advisory Committee comprised of a diverse set of stakeholders with both a research and long-term care subcommittee structure;
- Establishment of the Healthy California for All Commission to develop a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system for all Californians.
- Enactment of a provision to expand full scope Medi-Cal coverage for undocumented adults up to age 26 using state General Funds to cover the costs of enrollment and coverage;

- Enactment of a California-specific individual mandate penalty and increased subsidies for individuals and families above the ACA amounts to provide stability in the individual insurance market and increase coverage for individuals with incomes above the Medi-Cal eligibility requirements; and

Implementation of the Governor's health policy agenda is the responsibility of the Secretary of the California Health & Human Services (CHHS) Agency, Mark Ghaly, MD. The Secretary oversees 15 Departments, including the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). While CalOptima works closely with DHCS, it is important to understand the larger health care context in California as the state continues to move towards additional integration across public programs to address social determinants of health and complex issues such as homelessness. This will require collaboration with multiple state-level departments which will impact CalOptima's work.

CHHS' current guiding principles include the following:

1. Adopt a culture of collaboration and innovation;
2. Focus on outcomes & value generation;
3. Use data to drive action;
4. Put the person back in person-centered; and
5. See the whole person. [v]

These principles will guide DHCS's work, and CalOptima can use it to help think proactively and strategically about likely actions that will be taken over the next several years. Some initiatives are starting to take shape at DHCS and should be factored into CalOptima's next strategic plan to ensure necessary resources will be available and that the health plan can be as proactive in its preparations as possible. While DHCS does not have a current strategic plan,[vi] the Department has shared priorities that are in-line with the CHHS vision to provide a better patient experience with improved outcomes and lower costs.

The following graphic, which may be updated in the next strategic plan, defines the high-level goals of DHCS. [vii] This highlights many of the same themes outlined by CHHS and CMS, including the focus on the member, providing high-quality care, and using public dollars in an effective and efficient manner.

With the rapid growth of the program due to the addition of the Medi-Cal expansion population in 2014, Medi-Cal is the largest Medicaid program in the nation, providing coverage to one-third of all Californians. In more recent years, Medi-Cal enrollment growth has leveled off (and even declined slightly), but the 2019-2020 Budget provision extending Medi-Cal eligibility to undocumented immigrants between the ages of 19-25 is projected to provide full-scope Medi-Cal coverage to an additional 138,000 individuals when it takes effect in 2020.[viii] As discussed above, however, it is possible enrollment will be lower than anticipated due to federal immigration policy.

Currently, DHCS is engaged in several initiatives and pilots that point to its direction to increase person-centered care and to integrate across programs. These include the Coordinated Care Initiative, Whole-Person Care Pilots, Health Homes, and the Whole-Child Model. CalOptima is currently involved with all these initiatives at some level and has demonstrated a commitment to being innovative and testing new programs that meet the strategic priorities of the state. As these pilots and programs are evaluated and DHCS determines how it will incorporate lessons learned into the broader Medi-Cal program, it is

inevitable there will be some expansion of the programs and some adjustments for the pieces that did not yield expected results. CalOptima is in a strong position to move forward with the state as these projects evolve and to provide input and feedback to DHCS to drive sustainable changes to the Medi-Cal program.

Key Medi-Cal initiatives underway at DHCS that will shape the future direction of the program, and impact CalOptima's work, are discussed below.

Expiration of Federal Section 1115 Medicaid Waiver (Medi-Cal 2020)

The current federal Section 1115 Medicaid waiver expires at the end of 2020. Currently, the entire managed care program (including the authority under which CalOptima operates) is included in the Section 1115 waiver. In addition, the waiver includes authorization for the Whole Person Care Pilots (WPCP), Public Hospital Redesign & Incentives in Medi-Cal (PRIME), the Global Payment Program, Dental Transformation Initiatives, the Drug Medi-Cal Organized Delivery System, California Children's Services (CCS) pilots, and the Coordinated Care Initiative (CCI). The federal government has changed its guidance to states regarding the calculation of "budget neutrality" (all Section 1115 waivers are required to demonstrate they do not cost the federal government more than would otherwise have been spent in the absence of the waiver), which will result in less federal funding for California under a new waiver. This shortfall will drastically reduce the amount of funding available for DHCS to invest in pilot programs and initiatives and will require the transition of many of the activities under the current waiver into sustainable models, which may involve moving those components into the managed care program. The theme of consolidation, alignment, and standardization across the Medi-Cal program is expected to be a significant part of the waiver renewal and is reflected in other activities by DHCS as outlined below. However, because many of these pilot programs, such as the WPCP, vary significantly in design and target populations by county, standardization will present unique challenges for each county, and DHCS will have to identify the components that will be included statewide.

DHCS California Advancing and Innovating Medi-Cal (CalAIM) Initiative

In 2018, DHCS convened a comprehensive set of stakeholders for its Care Coordination Assessment Project to discuss how to improve Medi-Cal care coordination and developed key themes and next steps that emerged from these meetings. [ix] Key finding included the desire to standardize benefits across counties, streamline assessments across programs, and reduce the number of carve-out benefits (such as specialty mental health, dental, and long-term care). DHCS has used the recommendations from the Care Coordination Assessment Project to develop its next set of policy initiatives and program changes, including the newly announced CalAIM initiative. CalAIM is a multi-year initiative with the following objectives: "(1) reducing variation and complexity across the delivery system; (2) identifying and managing member risk and need through population health management strategies; and (3) improving quality outcomes and driving delivery system transformation through value-based initiatives and payment reform."[x]

Throughout 2019 and 2020, DHCS intends to engage stakeholders to discuss both CalAIM and the renewal of Medi-Cal's federal waivers. DHCS has indicated it will transition all existing managed care authorities into a single, consolidated 1915(b) waiver that will include the Medi-Cal Managed Care Plans, the County Mental Health Plans, the Drug-Medi-Cal Organized Delivery System Plans, and the Dental Managed Care Plans. While DHCS has yet to release a detailed CalAIM proposal, they have shared some

limited information about the stakeholder workgroups that will be formed to provide input on the development of CalAIM.[xi] Workgroup topics include: (1) Population Health Management and Annual Health Plan Open Enrollment; (2) NCQA Accreditation; (3) Enhanced Cared Management and In-Lieu-of-Services; (4) Behavioral Health; and (5) Full Integration Pilots.

DHCS Stakeholder Advisory Committee

The DHCS Stakeholder Advisory Committee (SAC) was originally established to provide input on the development of the federal Section 1115 waiver. However, it has evolved over time to become the body DHCS uses to discuss issues well beyond the federal waiver, including health care reform and state developments more broadly. With the upcoming renewal of the Section 1115 waiver, DHCS has stated it will begin to discuss the specific proposals related to transitioning the Medi-Cal 2020 waiver into a sustainable model in October 2019.

DHCS Behavioral Health Stakeholder Advisory Committee

The Behavioral Health Stakeholder Advisory Committee (BH-SAC) is a newly formed, stakeholder workgroup focused on the issues related to the delivery of behavioral health services in Medi-Cal. The current system, which is bifurcated between the health plans (which are responsible for delivering mild-to-moderate services) and the counties (which are responsible for specialty mental health services), is under scrutiny and criticism from many stakeholders. DHCS recently received federal approval to extend the current federal Section 1915(b) Specialty Mental Health Services waiver to the end of 2020 to align with renewal of the Section 1115 waiver. As noted above, DHCS intends to submit a single consolidated federal Section 1915(b) waiver that will include all of the managed care programs across Medi-Cal, including specialty mental health services.

Prescription Drugs Executive Order

On his first day in office, Governor Newsom announced an Executive Order (E.O.) intended to control rising pharmacy costs.[xii] The E.O. includes a shift to bulk purchasing for all government programs, including Medi-Cal (the largest purchaser of prescription drugs in the state). This will involve carving-out the Medi-Cal pharmacy benefit from the health plans, so the state can negotiate for all its programs collectively, which it anticipates will result in lower costs. Even with concerns from Medi-Cal stakeholders and opposition from health plans, DHCS has been instructed to move forward on a very aggressive timeline and complete the transition by January 2021. DHCS recently released an RFP to select a single vendor to manage the entire pharmacy benefit under a fee-for-service arrangement.[xiii] Despite running counter to other actions designed to integrate services and benefits across the Medi-Cal program, it appears pharmacy will be carved-out. Once the shift occurs, the Medi-Cal health plans will need to be prepared to work with the state's pharmacy vendor to access pharmacy data for their members and coordinate care.

DHCS Managed Care Accountability Set

In early 2019, DHCS announced a major change in quality reporting requirements for the Medi-Cal health plans: health plans must report on the complete CMS Core Measures Set for both adults and children (known as the Managed Care Accountability Set in California). [xiv] This represents a significant increase in the number of measures reported and is being implemented for Measurement Year 2019. Additionally, DHCS currently requires that health plans meet a Minimum Performance Level (MPL) of 25

percent and will move to a 50 percent MPL effective for the 2019 Measurement Year. While negotiations between the health plans and DHCS have helped reduce the administrative burden and potential for sanctions in the first year of the transition, this is a heavy lift for the health plans and DHCS, and another indicator of a new Administration that is determined to make changes and maintain aggressive implementation timelines. With themes of quality and value throughout both the federal and state priorities, it is likely the pressure to demonstrate high-value care will continue to be a growing focus of DHCS.

Future of the Coordinated Care Initiative

The Coordinated Care Initiative (CCI), which is currently operating in seven counties, includes the mandatory enrollment of dual eligibles into Medi-Cal Managed Care, implementation of a managed long-term services and supports (MLTSS) benefit, and assumption of risk by the health plans for long-term care placements. [xv] It also includes the Cal MediConnect (CMC) duals demonstration, which has been extended through 2022.[xvi] The CCI has been placed into state law with no sunset date and an expansion of certain elements would be in line with other efforts by DHCS to align and integrate benefits statewide. Notably, DHCS recently announced that, starting in January 2021 (which aligns with the waiver renewal timeline), it will carve-in long-term care benefits to all its managed care models, signaling the move towards standardization of benefits across the state.

The CCI program requires federal waiver authority, and the CMC program requires continued federal approval and negotiation of a three-way contract between DHCS, CMS, and the health plans. The future and status of this program is less certain and may be resolved as part of the Section 1115 waiver discussions and negotiations.

Medi-Cal Managed Care Rates

DHCS must submit actuarially-sound managed care rates to CMS for review and approval. The capitation rates paid to health plans are tied directly to the Medi-Cal benefits included in the health plan contracts. Per federal regulations 42 CFR Section 438.4 (a) defines actuarially sound capitation rates as *"projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO…for the time period and the population covered under the terms of the contract."* Meaning that Medi-Cal Managed Care Plan capitation rates only reflect the costs of providing services and populations included in the contract with DHCS.

The complicated rates structure, which has evolved over many years, has led to thousands of individual rate cells that have to be calculated by DHCS every year. DHCS has been moving to speed up its rate development process, which is currently under almost a two-year delay, to provide more timely rates to health plans and to meet CMS requirements for prospective rate setting. In addition, DHCS has recently indicated it is examining how to move to a regional rate-setting model, which would streamline their work and require significantly fewer rate cells. However, many factors will continue to complicate the rate development process, some of which are outside of DHCS' control. These include directed payments to certain providers, retroactive implementation of benefits, delays in CMS review and approval, and other legislative and administrative activities that impact the Medi-Cal program. As DHCS moves to increase value-based payments and streamline the rate setting process, providing quality data that reflects the cost of providing high-value care will become even more important. Health plans will

want to provide input on these transitions to identify downstream and unintended negative consequences and to promote the timely payment of rates.

Encounter Data Reporting

DHCS has continued to put significant pressure on the health plans to provide complete, accurate, and timely encounter data. Under federal Medicaid regulations, CMS can withhold federal funds if the state does not submit this data as required. Additionally, the Department of Managed Health Care (DMHC) has initiated an encounter data taskforce that is charged with working to standardize and improve encounter data reporting across all health plans (Medi-Cal, Commercial, Medicare, etc.). CalOptima will need to be prepared to respond to any future actions that the state takes as it works to enhance encounter data reporting, which is used for both utilization oversight and rate setting purposes. CalOptima should proactively identify where it can improve encounter data collection and be prepared to work collaboratively with its networks and DHCS.

County Landscape

CalOptima is an integral part of the business community and the health care sector in Orange County. It is important to understand how the federal and state priorities intersect with the local landscape and the needs of the community.

Health Insurance Coverage in Orange County

As shown in the table below, Orange County has over 30 percent of its population enrolled in public programs, which includes Medicare and Medi-Cal, in 2017. [xvii] As the sole Medi-Cal plan in the County, CalOptima has a unique position to impact care delivery and examine ways to reach the additional uninsured. For example, CalOptima offers several plans for individuals with both Medicare and Medi-Cal. Its PACE programs for frail seniors has experienced successful growth, in part due to its implementation of the alternative care setting model allowing members to receive services at local Community-Based Adult Services locations. It's OneCare Connect (Cal MediConnect Plan), on the other hand has experienced enrollment and financial performance challenges; the future of this program is uncertain as CMS has approved extension of this program through 2022.

Current Health Insurance Coverage Type	Statewide	Orange County
Uninsured	7.3%	6.7%
Medicare & Medicaid (Dual Eligibles)	4.3%	3.0%
Medicare	10.9%	11.2%
Medicaid	25.0%	19.1%
Employment-based	44.4%	51.8%
Privately Purchased	6.5%	7.5%
Other Public	1.5%	0.7%

Competitive Orange County Labor Market

According to the 2019 Orange County Community Indicators Report, the cost-of-living in Orange County is 91 percent higher than the national average, and among the highest in California. The high cost-of-living is driven largely by high housing costs. In addition, Orange County's unemployment rate (3.0 percent as of June 2019) continues its six-year trend of outperforming state and national unemployment rates (4.2 percent and 3.8 percent respectively).[xviii] The high cost-of-living coupled with a low unemployment rate are both challenges for CalOptima. As a public plan, CalOptima has difficulty competing with the private sector for staff in terms of salary. In addition, the low unemployment rate in the County means the hiring environment is very competitive.

Community Collaboration

Community Engagement

CalOptima believes in strengthening its partnerships by enhancing communications with local community organizations and supporting these important partners serving CalOptima's members' health care needs. For fiscal year (FY) 2018-2019, CalOptima participated in 126 community events to engage members and the public about CalOptima and its programs, health care and support services. Additionally, CalOptima hosts the quarterly Community Alliances Forum, which is designed to keep CalOptima connected to the health plan's community stakeholders. CalOptima also participates in more than 30 collaborative meetings throughout Orange County. Finally, CalOptima understands the importance of keeping the local community informed about health plan activities. Through their monthly community announcements and quarterly e-newsletter (known as "Community Connections"), the CalOptima provides updates on initiatives and shares information about events and training with more than 2,500 individuals and organizations.

System of Care Data Integration

The County of Orange has launched integrated data initiative for the County's System of Care for individuals experiencing homelessness. When complete, this initiative will support information sharing across county agencies touching county residents for services such as health care, law enforcement, court system, social services and other community resources. Shared data will enhance the coordination of services for "high utilizers" of the County's System of Care and may provide earlier opportunities for early intervention before residents become high utilizers. CalOptima will explore opportunities for data exchange to benefit the mutual individuals we serve.

Behavioral Health/Be Well OC

In 2018, local public and private stakeholders came together to work on behavioral health issues. In addition to CalOptima, key participants include the County Board of Supervisors, Providence St. Joseph Health, and Kaiser Permanente. Under this initiative, a regional wellness center is envisioned in Orange County to serve individuals with mental health needs regardless of payor source. The Be Well OC initiative integrates across silos to address social determinants of health and recognizes issues related to the justice system and housing have a significant impact on health and must be considered as part of comprehensive solution. This mirrors concerns, and priorities highlighted by the state and federal

government. CalOptima is well positioned to leverage this local experience to demonstrate its commitment to population health management and effective delivery system transformation.

Homelessness

In Orange County, as across the state, the homeless population has increased significantly over the past few years because of increased housing costs and stagnant wages. To address this problem Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health, health care, housing, community corrections, housing, benefits and support services.[xix] The county's WPCP is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care – As part of the Whole Person Care program, services provide post-acute care for update to 90-day stay for homeless CalOptima Members.
- Medical Respite Care – As an extension to recuperative care program, CalOptima provides additional respite care beyond 90 days of recuperative care under the Whole Person Care program.
- Clinic Field Teams – In collaboration with Federally Qualified Community Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, the pilot program provides immediate acute treatment/urgent care to homeless CalOptima Members.
- Homeless Clinic Access Program – The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventative care services at Orange County shelters.
- Hospital Discharge Process for Members Experiencing Homelessness – Support is designed to assist hospitals with the increased cost associated with discharge planning under the new State Legislative requirements.

As noted above, addressing homelessness is one of the Governor's priorities, and CalOptima can expect the state will be looking for innovative partners to address this public health crisis.

Health Homes Program (HHP)

As was noted above, one of the initiatives DHCS has implemented to increase person-centered care and to integrate across programs is HHP. CalOptima has elected to bring this program to Orange County to provide increased coordinates care for its highest risk Medi-Cal members. Eligible members choosing to participate and will receive high touch services, such as in-person health needs assessment, accompaniment to key medical appointments and housing navigation and sustainability services.

Whole Person Care Pilot Transition to CalOptima

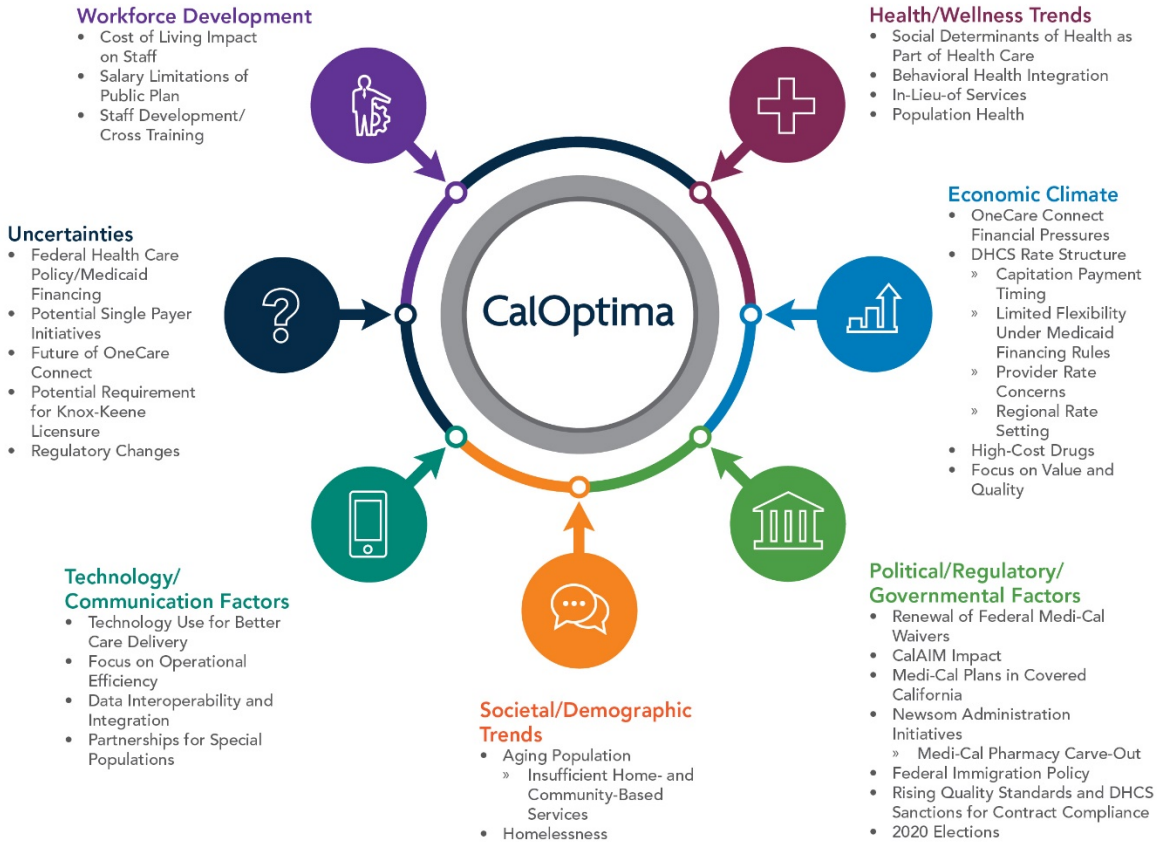
As was noted above, the WPCP are expected to transition to the Medi-Cal managed care plans when the waiver expires at the end of 2020. Orange County's Health Care Agency is the lead entity for the WPCP, and CalOptima has a limited role to provide personal care coordination services and access to covered Medi-Cal benefits. Because details are limited at this time, and it is unclear how DHCS may restructure

the individual WPCPs as they transition into managed care, CalOptima will have to be prepared to work collaboratively with the WPCP stakeholders once DHCS releases more detailed guidance and timeframes. HHP implementation will provide a foundation for this transition.

CalOptima Health Networks and Access

Across California, there are concerns about access to care, rising cost of living, and a lack of physicians and other health workers. These issues are particularly acute in the Medi-Cal program, which recently launched a physician loan forgiveness program to encourage new physicians to serve this population. CalOptima is engaged in an assessment of its health network structure and reimbursement arrangements to develop stronger networks with value-based payment arrangements. The Delivery System Study, being conducted by Pacific Health Consulting Group, is expected to be finalized in early 2020 and will present options for CalOptima and its contracted health networks to consider. It is increasingly challenging to recruit and maintain providers with the low reimbursement rates and significant administrative workload associated with the Medi-Cal program (e.g., all providers must now enroll with DHCS). Continued investment in its health networks and collaboration with providers will allow CalOptima to continue to be innovative and meet the needs of all its members.

Environmental Considerations



[i] https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/NewsandPublications/2019/2019-09_FastFacts_508.ashx

[ii] Source: https://www.cms.gov/about-cms/story-page/our-16-strategic-initiatives.html

[iii] Kaiser Family Foundation Fact Sheet, "Changes to 'Public Charge' Inadmissibility Rule: Implications for Health and Health Coverage," August 2019 Update. Available at: http://files.kff.org/attachment/Fact-Sheet-Changes-to-Public-Charge-Inadmissibility-Rule-Implications-for-Health-and-Health-Coverage

[iv] https://www.uscis.gov/legal-resources/final-rule-public-charge-ground-inadmissibility

[v] https://www.chhs.ca.gov/wp-content/uploads/2019/07/CHHSA-Guiding-Principles.pdf

[vi] The most recent DHCS strategic plan expired in 2018. Available at: https://www.dhcs.ca.gov/Documents/StrategicPlan/DHCS%20Strategic%20Plan%209-14-15.pdf

[vii] https://www.dhcs.ca.gov/Documents/StrategicPlan/DHCS%20Strategic%20Plan%209-14-15.pdf

[viii] http://www.ebudget.ca.gov/2019-20/pdf/BudgetSummary/FullBudgetSummary.pdf

[ix] https://www.dhcs.ca.gov/services/Pages/Care-Coordination-Assessment-Project.aspx
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[xiv] https://www.dhcs.ca.gov/dataandstats/Pages/Core-Set-Measures-Reporting.aspx
[xv] https://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx
[xvi] http://calduals.org/
[xvii] Source: CHIS, 2017 California Health Interview Survey data. Available at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[xviii] Orange County 2019 Community Indicators Report. Available at: https://www.ocbc.org/wp-content/uploads/2019/09/CommIndicators_Report_091219-WEB.pdf
[xix] http://ochmis.org/wp-content/uploads/2019/08/2019-PIT-FINAL-REPORT-7.30.2019.pdf

Board of Directors Meeting
October 1, 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

- 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

Strategic Plan 2017–2019

Better. Together.

Final Report

January 1, 2017–December 31, 2019

A Public Agency

CalOptima

Better. Together.

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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.

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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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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STRATEGIC PLAN 2020–2022

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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.

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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

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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

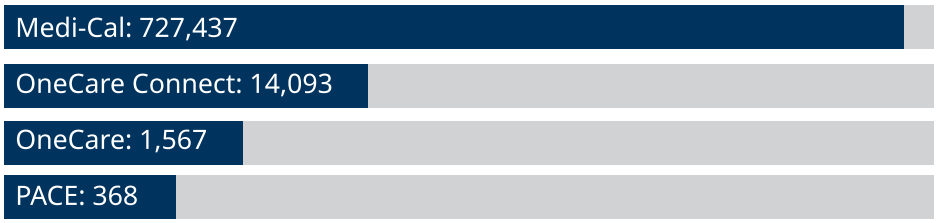
Medi-Cal (California's Medicaid Program): For low-income children, adults, seniors and persons with disabilities.

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:



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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

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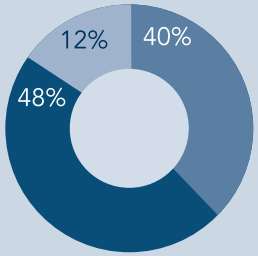
CalOptima Profile

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.

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Health Care Landscape Review

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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.

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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.

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Health Care Landscape Review (continued)

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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.

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Strategic Plan Development Process

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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.

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Strategic Priorities and Objectives

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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

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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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A Public Agency

CalOptima

Better. Together.

505 City Parkway West, Orange, CA 92868
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.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

12. Consider Approval of Modifications to Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 347-3261
Tracy Hitzeman, RN, Executive Director, Clinical Operations, (714) 246-8549

Recommended Action(s)

Approve modifications to Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N pursuant to CalOptima's regular review process and consistent with regulatory requirements.

Background/Discussion

CalOptima staff regularly reviews agency Policies and Procedures to ensure that they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations and laws as well as CalOptima operations.

> ***Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N*** outlines the criteria and processing of requests for Intermediate Care Facility services. Regional Center of Orange County determines all facility placement and level of care needs for developmentally disabled Members. Initial authorization and re-authorization requests for these services are completed by CalOptima following this certification. Proposed modifications include minor verbiage changes and updates to standard CalOptima glossary definitions and titles of resources.

Fiscal Impact

The recommended action to modify CalOptima Policy GG.1802 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt the presented revised policy. The updated policy will supersede the prior version.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N (redline and clean)

/s/ Richard Sanchez — *11/24/2020*

Authorized Signature — **Date**

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Policy:	GG.1802
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N**
Department:	Medical Management
Section:	Long Term Services and Supports
Interim CEO Approval:	
Effective Date:	06/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy outlines the ~~requirements for reviewing and processing a Long Term Care (LTC) Authorization Request and~~ criteria for a Member's admission to, continued stay in, or discharge from an Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N~~).~~), and the requirements for reviewing and processing a ICF/DD, ICF/DD-H and ICF/DD-N Notification Form.

II. POLICY

A. All admissions requiring ICF/DD, ICF/DD-H, or ICF/DD-N level of services are subject to certification by the Regional Center and the attending physician for placement of all developmentally disabled Members.

B. Regional Center shall determine the facility placement and level of care for a developmentally disabled Member.

C. The initial and reauthorization requests shall be initiated by the ICF/DD, ICF/DD-H and ICF/DD-N facilities. All authorization requests must be submitted with a Certification for Special Treatment Program Services (HS 231) form, as required by the Department of Developmental Services (DDS). All Members ~~will~~must be approved by Regional Center prior to submission of the HS 231.

D. The CalOptima Long Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stays in, or discharge from an ICF/DD, ICF/DD-H, or ICF/DD-N pursuant to Title 22, California Code of Regulations (C.C.R.) sections 51343, 51343.1 and 51343.2, as well as the California Department of Health Care Services (DHCS) standard clinical criteria for level of care.

E. When the Regional Center determines a Member meets ICF/DD, ICF/DD-H, or ICF/DD-N level of care criteria and authorizes up to two (2) years of service, as documented on HS 231, the CalOptima LTSS Department shall document the authorization as requested in the Medical Management System and provide an authorization number to the admitting facility.

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F. An ICF/DD, ICF/DD-H, and ICF/DD-N shall submit a completed ~~LTC ARF~~ICF/DD, ICF/DD-H and ICF/DD-N Notification Form (Sections I, II, ~~IV and V~~III) signed by a physician and the HS 231 signed by Regional Center, within twenty-one (21) calendar days after a Member's admission to the facility.

~~G. If an ICF/DD, ICF/DD-H, or ICF/DD-N submits an LTC ARF after the twenty-one (21) calendar day requirement, but the LTC ARF meets the level of care requested, CalOptima shall subject the LTC ARF to a fifteen percent (15%) payment reduction.~~

~~H.~~G. CalOptima's LTSS Department will enter a reauthorization into the Medical Management System when an ICF/DD, ICF/DD-H, ICF/DD-N sends the Regional Center-signed HS 231 form with reauthorization information to CalOptima.

~~I.~~H. CalOptima shall ensure continuity of care for Members residing in an ICF/DD, ICF/DD-H, ICF/DD-N in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning~~Medi-Cal Beneficiaries Who Transition~~ into CalOptima Services.

~~J.~~I. A Member may elect to use their Share of Cost (SOC) funds to pay for necessary, Non-Covered Medical Services or remedial care services, supplies, equipment and prescription drugs that are prescribed by a physician and part of the Plan of Care authorized by the Member's attending physician. The medical service is considered a non-covered benefit if one of the following occurs:

1. The medical service is rendered by a non-Medi-Cal provider; or

2. The medical service does not meet ~~medical necessity~~Medical Necessity and results in a denial. CalOptima's Utilization Management Department will issue the Notice of Action (NOA) to the ICF facility to include information on a Member's appeal rights, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

III. PROCEDURE

A. ICF/DD, ICF/DD-H, and ICF/DD-N facilities shall initiate authorization requests and submit the HS 231 form, signed by the Regional Center ~~personnel~~Director, to the CalOptima LTSS Department to document the authorization as requested in the Medical Management System, and provide an authorization number to the admitting facility.

B. ~~If the LTC ARF~~If the ICF/DD, ICF/DD-H and ICF/DD-N Notification Form and the HS 231 forms required attachments are incomplete or not signed as required, the CalOptima LTSS Department shall request the facility resubmit completed required documentation.

C. Upon notification by the facility of a Member's discharge, the CalOptima LTSS Department shall close the active ~~LTC~~ authorization effective the day of discharge. The facility shall notify CalOptima within ~~three (3) business days~~twenty-four (24) hours of a Member's discharge by submitting the Discharge Disposition Form.

D. Share of Cost (SOC) Spending

1. An ICF/DD, ICF/DD-H, or ICF/DD-N shall be responsible for:

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a. Performing an eligibility verification each month for CalOptima Member who is residing in the ICF facility;

b. Performing SOC clearance transactions when a CalOptima Member with an unmet SOC is admitted, or SOC exceeds the total charges of the contracted rate for a given month's stay;

c. Billing CalOptima's Member for the entire SOC if the CalOptima Member has not spent any of the SOC in the month's stay; and

d. Maintaining the physician's prescriptions for SOC expenditures in CalOptima's Member's medical record.

IV. ATTACHMENT(S)

~~A. CalOptima Long Term Care (LTC) Authorization Request Form (ARF)~~
~~B.~~A. ICF/DD, ICF/DD-H and ICF/DD-N Notification Form
~~C.~~B. Certification of Special Treatment Program Services Form (HS 231)
~~D.~~C. Discharge Disposition Form~~.~~

V. REFERENCE(S)

A. Department of Health Care Services (DHS) 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
~~B. Health and Safety Code, § 1250~~
B. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
~~C.~~D. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
~~D.~~E. Medi-Cal Long Term Care Provider Manual, Section, Utilization Review: ICF/DD, ICF/DD-H, ICF/DD-N Facilities
~~E.~~F. Memorandum of Understanding (MOU) with the Regional Center dated 11/10/2011
~~F.~~G. Title 22, California Code of Regulations (C.C.R.), §§ 51212, 51343, 51343.1, 51343.2,76000, 76079, 76345, and 76853
~~G.~~H. Welfare and Institutions Code, §§ 14087.55,14087.6, 14087.95, and 14103.6

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/03/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
11/01/2002	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal
Revised	02/01/2007	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal
Revised	07/01/2015	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal
Revised	01/01/2016	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	06/01/2017	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	TBD	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal

IX. GLOSSARY

Term	Definition
Developmental Disability	A disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.
Intermediate Care Facility (ICF)	A health facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or SNF that meets the standards specified in Title 22, California Code of Regulations, Section 51212, and has been certified by DHCS for participation in the Medi-Cal program. ~~A health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.~~
Intermediate Care Facility/~~DD (~~Developmentally Disabled (ICF/DD)~~)~~	A facility that provides 24-~~hour~~Hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
Intermediate Care Facility/ Developmentally Disabled – Habilitative (ICF/DD-H)~~DD-H (Habilitative)~~	A facility with a capacity of 4 to 15 beds that provides 24-~~hour~~Hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
Intermediate Care Facility/ Developmentally Disabled – Nursing (ICF/DD-N)~~DD-N (Nursing)~~	A facility with a capacity of 4 to 15 beds that provides 24-~~hour~~Hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury , achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).~~.~~

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Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Covered Medical 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 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.
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).
Share of Cost (SOC)	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.

Policy:	GG.1802
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N**
Department:	Medical Management
Section:	Long Term Services and Supports
Interim CEO Approval:	
Effective Date:	06/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy outlines the criteria for a Member's admission to, continued stay in, or discharge from an Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N), and the requirements for reviewing and processing a ICF/DD, ICF/DD-H and ICF/DD-N Notification Form.

II. POLICY

A. All admissions requiring ICF/DD, ICF/DD-H, or ICF/DD-N level of services are subject to certification by the Regional Center and the attending physician for placement of all developmentally disabled Members.

B. Regional Center shall determine the facility placement and level of care for a developmentally disabled Member.

C. The initial and reauthorization requests shall be initiated by the ICF/DD, ICF/DD-H and ICF/DD-N facilities. All authorization requests must be submitted with a Certification for Special Treatment Program Services (HS 231) form, as required by the Department of Developmental Services (DDS). All Members must be approved by Regional Center prior to submission of the HS 231.

D. The CalOptima Long Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stays in, or discharge from an ICF/DD, ICF/DD-H, or ICF/DD-N pursuant to Title 22, California Code of Regulations (C.C.R.) sections 51343, 51343.1 and 51343.2, as well as the California Department of Health Care Services (DHCS) standard clinical criteria for level of care.

E. When the Regional Center determines a Member meets ICF/DD, ICF/DD-H, or ICF/DD-N level of care criteria and authorizes up to two (2) years of service, as documented on HS 231, the CalOptima LTSS Department shall document the authorization as requested in the Medical Management System and provide an authorization number to the admitting facility.

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F. An ICF/DD, ICF/DD-H, and ICF/DD-N shall submit a completed ICF/DD, ICF/DD-H and ICF/DD-N Notification Form (Sections I, II, III) signed by a physician and the HS 231 signed by Regional Center, within twenty-one (21) calendar days after a Member's admission to the facility.

G. CalOptima's LTSS Department will enter a reauthorization into the Medical Management System when an ICF/DD, ICF/DD-H, ICF/DD-N sends the Regional Center-signed HS 231 form with reauthorization information to CalOptima.

H. CalOptima shall ensure continuity of care for Members residing in an ICF/DD, ICF/DD-H, ICF/DD-N in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

I. A Member may elect to use their Share of Cost (SOC) funds to pay for necessary, Non-Covered Medical Services or remedial care services, supplies, equipment and prescription drugs that are prescribed by a physician and part of the Plan of Care authorized by the Member's attending physician. The medical service is considered a non-covered benefit if one of the following occurs:

1. The medical service is rendered by a non-Medi-Cal provider; or

2. The medical service does not meet Medical Necessity and results in a denial. CalOptima's Utilization Management Department will issue the Notice of Action (NOA) to the ICF facility to include information on a Member's appeal rights, in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

III. PROCEDURE

A. ICF/DD, ICF/DD-H, and ICF/DD-N facilities shall initiate authorization requests and submit the HS 231 form, signed by the Regional Center Director, to the CalOptima LTSS Department to document the authorization as requested in the Medical Management System, and provide an authorization number to the admitting facility.

B. If the ICF/DD, ICF/DD-H and ICF/DD-N Notification Form and the HS 231 forms required attachments are incomplete or not signed as required, the CalOptima LTSS Department shall request the facility resubmit completed required documentation.

C. Upon notification by the facility of a Member's discharge, the CalOptima LTSS Department shall close the active authorization effective the day of discharge. The facility shall notify CalOptima within twenty-four (24) hours of a Member's discharge by submitting the Discharge Disposition Form.

D. Share of Cost (SOC) Spending

1. An ICF/DD, ICF/DD-H, or ICF/DD-N shall be responsible for:

a. Performing an eligibility verification each month for CalOptima Member who is residing in the ICF facility;

b. Performing SOC clearance transactions when a CalOptima Member with an unmet SOC is admitted, or SOC exceeds the total charges of the contracted rate for a given month's stay;

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c. Billing CalOptima's Member for the entire SOC if the CalOptima Member has not spent any of the SOC in the month's stay; and

d. Maintaining the physician's prescriptions for SOC expenditures in CalOptima's Member's medical record.

IV. ATTACHMENT(S)

A. ICF/DD, ICF/DD-H and ICF/DD-N Notification Form
B. Certification of Special Treatment Program Services Form (HS 231)
C. Discharge Disposition Form

V. REFERENCE(S)

A. Department of Health Care Services (DHS) 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
B. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
E. Medi-Cal Long Term Care Provider Manual, Section, Utilization Review: ICF/DD, ICF/DD-H, ICF/DD-N Facilities
F. Memorandum of Understanding (MOU) with the Regional Center dated 11/10/2011
G. Title 22, California Code of Regulations (C.C.R.), §§ 51212, 51343, 51343.1, 51343.2,76000, 76079, 76345, and 76853
H. Welfare and Institutions Code, §§ 14087.55,14087.6, 14087.95, and 14103.6

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/03/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
11/01/2002	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal
Revised	02/01/2007	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2015	GG.1802	ARF Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, ICF/DD-N	Medi-Cal
Revised	01/01/2016	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	06/01/2017	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal
Revised	TBD	GG.1802	Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N	Medi-Cal

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IX. GLOSSARY

Term	Definition
Developmental Disability	A disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.
Intermediate Care Facility (ICF)	A health facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or SNF that meets the standards specified in Title 22, California Code of Regulations, Section 51212, and has been certified by DHCS for participation in the Medi-Cal program.
Intermediate Care Facility/Developmentally Disabled (ICF/DD)	A facility that provides 24-our personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
Intermediate Care Facility/ Developmentally Disabled – Habilitative (ICF/DD-H)	A facility with a capacity of 4 to 15 beds that provides 24-Hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
Intermediate Care Facility/ Developmentally Disabled – Nursing (ICF/DD-N)	A facility with a capacity of 4 to 15 beds that provides 24-Hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury , achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
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.

Term	Definition
Non-Covered Medical 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 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.
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).
Share of Cost (SOC)	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.

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P.O. Box 11045
Orange, CA 92856
Phone: 714-246-8444
Fax: 714-246-8843

ICF/DD, ICF/DD-H and ICF/DD-N Notification Form

☐ **Initial** ☐ **Re-Authorization** ☐ **Bed Hold/Leave of Absence**

SECTION I

Bed Hold Start Date: _____ Bed Hold End Date: _____
Bed Hold Start Date: _____ Bed Hold End Date: _____
LOA Start Date: _____ LOA End Date: _____
LOA Start Date: _____ LOA End Date: _____
LOA Start Date: _____ LOA 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: _____ ☐ M ☐ F Date of Birth: _____ Age: _____
Mailing Address: _____ City: _____ ZIP: _____ Phone: _____
CIN #: _____ Aid Code: _____ County Code: _____

Facility Name: _____
Facility Address: _____
City: _____ ZIP: _____
Phone: _____ FAX: _____
Facility Provider ID #/NPI: _____
Former Facility: _____ Office Contact #: _____
Diagnosis: _____

Physician Name: _____
Physician Address: _____
City: _____ ZIP: _____
Phone: _____ FAX: _____
Physician Medi-Cal ID #: _____
Physician Signature: _____
ICD-10 Code: _____

AUTHORIZATION REQUEST

☐ **ICFDD** ☐ **4–6 Bed ICF-DDH** ☐ **7–15 Bed ICF-DDH** ☐ **4–6 Bed ICF-DDN** ☐ **7–15 Bed ICF-DDN**

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

☐ Form HS-231 Completed

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: _____ **Date:** _____

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CERTIFICATION FOR SPECIAL TREATMENT PROGRAM SERVICES

(Read Instructions on Reverse Before Completing Form)

PART I—Completed by facility

Date

FOR OFFICIAL USE

Beneficiary name and address

Medi-Cal Identification number

Birth date | Age | Sex M F

Facility name and address

Guardian/Representative name and address

Program Category:
- ❒ Developmentally Disabled
  - ❒ ICF/DD
  - ❒ ICF/DDH
  - ❒ ICF/DDN
- ❒ Mentally Disordered

Part II—Completed by designee of regional center director/local mental health director

❒ Grant
❒ Deny

List below supportive information for this recommendation

Part III–Certification by:

❒ Regional Center Director
❒ Local Mental Health Director

❒ You are authorized to claim payment for treatment as recommended

From _____

To _____

which is a total of

_____ days

❒ Request denied
Comments:

Signature	Date	Signature	Date
Title	Affiliation	Title	

FORM DISTRIBUTION:

Developmentally Disabled: Original–facility; Copies–regional center director/designee
Mentally Disordered: Original–facility; Copies–local mental health director/designee

PROCEDURES FOR CERTIFICATION OF CLIENT
ELIGIBILITY FOR SPECIAL TREATMENT PROGRAM SERVICES

1. Upon completion of the client assessments, the designee of the Regional Center Director or the Local Mental Health Director shall forward the original of the client assessment form to the Regional Center Director or the Local Mental Health Director along with a certification form with his recommendation to certify or deny certification of each client assessed. The designee shall also retain one copy of the client assessment form for his files.

2. The facility shall retain one copy of the client assessment form in the client's chart, and forward one copy to the Department with the completed application package.

3. The designee shall recommend program certification based on the following criteria:

   3.1 **Developmentally Disabled**

   3.1.1 The client shall have a primary or secondary diagnosis of a developmental disability.

   3.1.2 The client shall be physically able to participate in and benefit from the program.

   3.1.3 The client assessment shall indicate significant areas in need of remediation.

   3.1.4 Clients whose assessment indicates that an optimal level of functioning has been reached, but whose medical condition requires that he receive the level of basic care provided by the facility, may be recommended for certification in order to maintain current functioning level.

   3.1.5 A client whose assessment indicates that an optimum level of functioning has been reached and whose physical condition is such that he can function at a lower level of care shall not be recommended for certification.

   3.2 **Mentally Disordered**

   3.2.1 Clients shall have a primary or secondary diagnosis of a mental disorder.

   3.2.2 Clients shall have a chronic psychiatric impairment whose adaptive functioning is at least of moderate impairment.

   3.2.3 Each recommendation for certification of eligibility shall describe the basis upon which such recommendation is based.

   3.2.4 Each recommendation for certification of eligibility shall include and describe the impairment level of adaptive functioning.

   3.2.5 Clients shall be physically capable to participate in the program.

   In addition to the above, clients may meet one or more of the following:

   3.2.6 The client is in the terminal stages of an acute psychiatric episode and requires intensive services in preparation for placement at a lower level of care.

   3.2.7 The client requires a significant number of individual interventions to modify antisocial or uncooperative behavior which prevents optimal participation in the treatment program.

   3.2.8 A client may be recommended for certification on a maintenance basis only if he exhibits bizarre or unusual behavior presenting management problems which cannot be solved in a general nursing care setting.

4. Whenever the designee recommends not to certify a client for special treatment program services, he shall specify the reason, or reasons, in writing to the Local Regional Center Director or the Local Mental Health Director.

5. Upon receipt of the client assessment forms and the certification forms with the recommendations of his designee, the Regional Center Director or the Local Mental Health Director shall make a determination of each client's eligibility.

6. Upon determination of whether or not to certify a client as eligible for special treatment program services, the Regional Center Director or Local Mental Health Director shall complete the certification form and transmit four (4) copies of the form to the facility.

7. Whenever certification is denied by the Regional Center Director or Local Mental Health Director, he shall give his reasons in the space provided on the certification form.

8. The Regional Center Director or Local Mental Health Director shall retain one copy of the certification form and transmit one copy to his designee.

9. Clients shall be re-certified as eligible for special treatment program services at specified intervals using the procedures outlined above.

Long-Term Services & Supports (LTSS)
Long-Term Care (LTC)
Phone: 714-246-8444
Fax: 714-246-8843

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Discharge Disposition Form

Nursing Facility Name			
Member Information	First Name:	Last Name:	
Admission Date:		Discharge/Expired Date:	☐ Expired?
Client Identification Number (CIN):		Date of Birth:	
Address: (Discharge Destination)			Phone Number:
Name of Physician(s):		LTC Authorization Number:	
Discharge Diagnoses	ICD-10 Code:	Description:	

IF EXPIRED, STOP HERE.

Discharge Plan

Most Recent Interdisciplinary Care Team (ICT) Meeting Date:			
Discharge Plan:			
Facility or Family Address Where Discharged:			
Selected Community PCP:	First Name:	Last Name:	
Phone:		NPI/PID from Provider Directory:	
Address:			

Discharge Reason/ Disposition (check all that apply)

- ☐ Discharged to acute hospital/higher level of care
- ☐ Discharged to another SNF/ICF/SA
- ☐ Discharged to residence/home of another
- ☐ Discharged to board and care
- ☐ Discharged to motel
- ☐ Ineligible with CalOptima
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer needs nursing facility services
- ☐ Poses risk to the health or safety of individuals in the nursing facility
- ☐ Other (specify):

Nursing Facility Offered Member Home- and Community-Based Services (HCBS) (check all that apply)

- ☐ 2-1-1 Orange County
- ☐ Aging & Disability Resource Connection
- ☐ AIDS Services Foundation
- ☐ Alzheimer's Association
- ☐ Assisted Living
- ☐ Board and Care Facility
- ☐ Case Management (CM) Program
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Dental
- ☐ Food Stamps
- ☐ Genetically Handicapped Person's Program (GHPP)
- ☐ Hemophilia Program
- ☐ Health Insurance Counseling & Advocacy Program (HICAP)
- ☐ Hospice
- ☐ Independent Living System
- ☐ In-Home Operations
- ☐ In-Home Supportive Services (IHSS)
- ☐ Legal Aid Society
- ☐ Meals on Wheels/Food Resource
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Orange County Housing
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Regional Center of Orange County
- ☐ Shelter
- ☐ Transportation
- ☐ Waiver Program
- ☐ Other (specify):

Print Member/Representative Party Name:	Post Discharge Phone No.:
Facility Representative Signature:	Date:

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Brigette Gibb, Executive Director, Human Resources, (714) 246-8405

Recommended Actions

1. Adopt Resolution adopting a Conflict of Interest Code ("Code") which supersedes all prior Conflict of Interest Codes and Amendments previously adopted; and
2. Upon adoption, direct the Clerk of the Board to submit the Code to the Orange County Board of Supervisors for review and approval.

Background

The Fair Political Practices Commission (FPPC) adopted a regulation, Title 2, California Code of Regulations, Section 18730, which contains terms for a standard Model Conflict of Interest Code ("Model Code") that, together with amendments thereto, may be adopted by local public agencies and incorporated by reference. The CalOptima Board of Directors adopted the Model Code by reference on January 6, 2011, and amended Exhibit A to CalOptima's Conflict of Interest Code on December 4, 2018.

When designated positions or reporting categories are added or changed, local agencies are required under Government Code section 87306 to make changes to the conflict of interest code to reflect these changed circumstances. On September 3, 2020 the CalOptima Board of Directors adopted a new Salary Schedule with an updated list of CalOptima employee positions and job titles. The proposed amendment to the list of Designated Filer Positions and Disclosure Categories (Exhibit A) reflects positions that make or participate in the making of governmental decisions which may foreseeably have a material financial effect on a financial interest. All individuals in designated positions will still be required to complete CalOptima's Supplement to FPPC Form 700. Changes have been proposed that update certain positions that have been added, deleted, or renamed.

In addition, the General Counsel for the California Fair Political Practices Commission (FPPC) has issued several memorandums opining that "conflict of interest code disclosure categories must be narrowly tailored to the type of economic interests that will foreseeably be affected by a designated employee's decision making." (See e.g., May 7, 2012, Memorandum from Zackery P. Morazzini, General Counsel of FPPC). Furthermore, in 2012, the FPPC adopted Title 2, California Code of Regulations, Section 18730.1, providing that designated positions are not required to report gifts outside an agency's jurisdiction if the purpose of disclosure of the source of the gift does not have some connection with or bearing upon the functions or duties of the position for which the reporting is required. Additional changes are also proposed to CalOptima's Conflict of Interest Code to ensure that disclosure requirements for each position is narrowly tailored to the type of economic interests that will foreseeably be materially affected by a designated employee's decision making.

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Rationale for Recommendation

Adoption of Resolution to adopt CalOptima's Conflict of Interest Code which supersedes all prior Conflict of Interest Codes and Amendments previously adopted is necessary to reflect updates to certain positions that have been added, deleted, or renamed. Disclosure categories have been updated to conform with the County of Orange Standard Disclosure Categories and to tailor the disclosure requirements to the type of economic interests that will foreseeably be affected by each position.

Fiscal Impact

There is no fiscal impact.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 20-1203-02 Adopting a Conflict of Interest Code Which Supersedes All Prior Conflict of Interest Codes and Amendments Previously Adopted
2. Draft Conflict of Interest Code – Exhibits A and B

/s/ Richard Sanchez *11/24/2020*

Authorized Signature **Date**

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RESOLUTION NO. 20-1203-02

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

ADOPTING A CONFLICT OF INTEREST CODE WHICH SUPERSEDES ALL PRIOR CONFLICT OF INTEREST CODES AND AMENDMENTS PREVIOUSLY ADOPTED

WHEREAS, the Political Reform Act of 1974, Government Code Section 81000 et seq. ("the Act"), requires a local government agency to adopt a Conflict of Interest Code pursuant to the Act and conduct a biennial review of Designated Positions and Disclosure Categories; and,

WHEREAS the Orange County Health Authority, dba CalOptima, has previously adopted a Conflict of Interest Code and that Code now requires updating; and,

WHEREAS, amendments to the Act have in the past and foreseeably will in the future require conforming amendments to be made to the Conflict of Interest Code; and,

WHEREAS, the Fair Political Practices Commission has adopted a regulation, Title 2, California Code of Regulations, Section 18730, which contains terms for a standard model Conflict of Interest Code, which, together with amendments thereto, may be adopted by public agencies and incorporated by reference to save public agencies time and money by minimizing the actions required of such agencies to keep their codes in conformity with the Political Reform Act.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. The terms of Title 2, California Code of Regulations, Section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission, and all additional guidance by the Fair Political Practices Commission, are hereby incorporated by reference, and together, with the attached Exhibits A and B in which members and employees are designated and disclosure categories are set forth, constitute the Conflict of Interest Code of the Orange County Health Authority, dba CalOptima.

Section 2. The provisions of all Conflict of Interest Codes and Amendments thereto previously adopted by the Orange County Health Authority, dba CalOptima are hereby superseded.

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Section 3. The CalOptima Clerk of the Board is hereby authorized and directed to forward a copy of this Resolution to the Clerk of the Orange County Board of Supervisors for review and approval by the Orange County Board of Supervisors as required by California Government Code Section 87303.

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

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Conflict of Interest Code
EXHIBIT A

Entity: **Other Misc. Authorities, Districts and Commissions**
Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Assistant Director	OC-41	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Associate Director, Customer Service	OC-41	COB	Unchanged
Associate Director, Information Services	OC-08	COB	Unchanged
Associate Director, Provider Network	OC-41	COB	Unchanged
Buyer	OC-01	COB	Unchanged
Buyer, Int.	OC-01	COB	Unchanged
Buyer, Sr.	OC-01	COB	Unchanged
Chief Counsel	OC-01	COB	Unchanged
Chief Executive Officer	OC-01	COB	Unchanged
Chief Financial Officer	OC-01	COB	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Chief Information Officer	OC-01	COB	Unchanged
Chief Medical Officer	OC-01	COB	Unchanged
Chief Operating Officer	OC-01	COB	Unchanged
Clerk of the Board	OC-06	COB	Unchanged
Clinical Pharmacist	OC-20	COB	Unchanged
Consultant	~~OC-30~~OC-01	Agency	Category Changed
Contract Administrator	OC-06	COB	Unchanged
Contracts Manager	OC-06	COB	Unchanged
Contracts Manager, Sr.	OC-06	COB	Added New 20200903
Reason: Adding new position/categoryy with job duties requiring completion of Form 700 to the ddesignated ffiler's list			
Contracts Specialist	OC-06	COB	Unchanged
Contracts Specialist, Int.	OC-06	COB	Unchanged
Contracts Specialist, Sr.	OC-06	COB	Unchanged

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Conflict of Interest Code
EXHIBIT A

Position	Disclosure Category	Files With	Status
Controller	OC-01	COB	Unchanged
Deputy Chief Counsel	OC-01	COB	Unchanged
Deputy Chief Medical Officer	OC-01	COB	Unchanged
Deputy Clerk of the Board	OC-01	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Director, Accounting	OC-01	COB	Unchanged
Director, Applications Management	OC-08	COB	Unchanged
Director, Audit and Oversight	OC-01	COB	Unchanged
Director, Behavioral Health Services	OC-41	COB	Unchanged
Director, Budget & Procurement	OC-01	COB	Unchanged
Director, Business Development	OC-41	COB	Unchanged
Director, Business Integration	OC-41	COB	Unchanged
Director, Case Management	OC-41	COB	Unchanged
Director, Claims Administration	OC-41	COB	Unchanged
Director, Clinical Outcomes	OC-01	COB	Unchanged
Director, Clinical Pharmacy	OC-01	COB	Unchanged
Director, Coding Initiatives	OC-06	COB	Unchanged
Director, Communications	OC-13	COB	Unchanged
Director, Community Relations	OC-41	COB	Unchanged
Director, Configuration & Coding	OC-06	COB	Unchanged
Director, Contracting	OC-01	COB	Unchanged
Director, COREC	OC-08	COB	Unchanged
Director, Customer Service	OC-41	COB	Unchanged
Director, Electronic Business	OC-06	COB	Unchanged
Director, Enterprise Analytics	OC-06	COB	Unchanged
Director, Facilities	OC-41	COB	Unchanged
Director, Finance & Procurement	OC-01	COB	Unchanged
Director, Financial Analysis	OC-01	COB	Unchanged
Director, Financial Compliance	OC-01	COB	Unchanged
Director, Fraud, Waste & Abuse and Privacy	OC-01	COB	Unchanged

Conflict of Interest Code
EXHIBIT A

Position	Disclosure Category	Files With	Status
Director, Government Affairs	OC-41	COB	Unchanged
Director, Grievance & Appeals	OC-41	COB	Unchanged
~~Director, Health Education & Disease Management~~ Director, Population Health Management	OC-41	COB	Title change 20200903
Reason: Title changed due to change in department name			
Director, Health Services	OC-41	COB	Unchanged
Director, Human Resources	OC-11	COB	Unchanged
Director, Information Services	OC-08	COB	Unchanged
Director, Long Term Support Services	OC-41	COB	Unchanged
Director, Medi-Cal Plan Operations	OC-41	COB	Unchanged
Director, Network Management	OC-41	COB	Unchanged
Director, OneCare Operations	OC-41	COB	Unchanged
Director, Organizational Training & Education	OC-11	COB	Unchanged
Director, PACE Program	OC-41	COB	Unchanged
Director, Process Excellence	OC-41	COB	Unchanged
Director, Program Implementation	OC-41	COB	Unchanged
Director, Project Management	OC-41	COB	Unchanged
Director, Provider Data Quality	OC-41	COB	Unchanged
Director, Provider Services	OC-41	COB	Unchanged
Director, Public Policy	OC-41	COB	Unchanged
Director, Quality (LTSS)	OC-41	COB	Unchanged
Director, Quality Analytics	OC-06	COB	Unchanged
Director, Quality Improvement	OC-41	COB	Unchanged
Director, Regulatory Affairs and Compliance	OC-01	COB	Unchanged
Director, Strategic Development	OC-41	COB	Unchanged
Director, Systems Development	OC-08	COB	Unchanged
~~Director,~~ Utilization Management	OC-41	COB	Unchanged
Director, Vendor Management	OC-01	COB	Added New 20200903
Reason: Adding new position/categoryy with job duties requiring completion of Form700 to the ddesignated ffiler's list			
Enterprise Analytics Manager	OC-06	COB	Unchanged
Executive Director, Behavioral Health Integration	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A

Position	Disclosure Category	Files With	Status
Executive Director, Clinical Operations	OC-01	COB	Unchanged
Executive Director, Compliance	OC-01	COB	Unchanged
Executive Director, Human Resources	OC-01	COB	Unchanged
Executive Director, Network Operations	OC-01	COB	Unchanged
Executive Director, Operations	OC-01	COB	Unchanged
Executive Director, Program Implementation	OC-01	COB	Unchanged
Executive Director, Public Affairs	OC-01	COB	Unchanged
Executive Director, Quality & Population Health Management	OC-01	COB	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
~~Executive Director, Quality Analytics~~	OC-06	COB	Deleted 20200903
Reason: Deleting position since it no longer exists in CalOptima			
Financial Analyst	OC-01	COB	Unchanged
Financial Analyst, Sr.	OC-01	COB	Unchanged
Financial Reporting Analyst	OC-01	COB	Unchanged
Litigation Support Specialist	OC-41	COB	Unchanged
Manager, Accounting	OC-01	COB	Unchanged
Manager, Actuary	OC-01	COB	Unchanged
Manager, Applications Management	OC-08	COB	Unchanged
Manager, Audit and Oversight	OC-01	COB	Unchanged
Manager, Behavioral Health	OC-41	COB	Unchanged
Manager, Business Integration	OC-06	COB	Unchanged
Manager, Case Management	OC-41	COB	Unchanged
Manager, Claims	OC-41	COB	Unchanged
Manager, Clinic Operations	OC-06	COB	Unchanged
Manager, Clinical Pharmacists	OC-20	COB	Unchanged
Manager, Coding Quality	OC-06	COB	Unchanged
Manager, Communications	OC-13	COB	Unchanged
Manager, Community Relations	OC-06	COB	Unchanged
Manager, Contracting	OC-41	COB	Unchanged
Manager, Creative Branding	OC-13	COB	Unchanged

Conflict of Interest Code
EXHIBIT A

Position	Disclosure Category	Files With	Status
Manager, Cultural & Linguistics	OC-06	COB	Unchanged
Manager, Customer Service	OC-41	COB	Unchanged
Manager, Decision Support	OC-06	COB	Unchanged
~~Manager, Disease Management~~ Manager, Population Health Management	OC-41	COB	~~Title change~~ 20200903
Reason: Title changed due to change in department name			
Manager, Electronic Business	OC-06	COB	Unchanged
Manager, Employment Services	OC-11	COB	Unchanged
Manager, Encounters	OC-06	COB	Unchanged
Manager, Environmental Health & Safety	OC-06	COB	Unchanged
Manager, Facilities	OC-41	COB	Unchanged
Manager, Finance	OC-01	COB	Unchanged
Manager, Financial Analysis	OC-01	COB	Unchanged
Manager, Government Affairs	OC-41	COB	Unchanged
Manager, Grievance and Appeals	OC-41	COB	Unchanged
Manager, Health Education	OC-41	COB	Unchanged
Manager, HEDIS	OC-06	COB	Unchanged
Manager, Human Resources	OC-11	COB	Unchanged
Manager, Information Services	OC-08	COB	Unchanged
Manager, Information Technology	OC-08	COB	Unchanged
Manager, Integration Government Liaison	OC-41	COB	Unchanged
Manager, Long Term Support Services	OC-41	COB	Unchanged
Manager, Marketing and Enrollment (PACE)	OC-06	COB	Unchanged
Reason: Title changed to designate department			
Manager Marketing & Outreach	OC-06	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Manager, Medical Data Management	OC-06	COB	Unchanged
Manager, Medi-Cal Program Operations	OC-41	COB	Unchanged
Manager, Member Liaison Program	OC-41	COB	Unchanged
Manager, Member Outreach & Education	OC-41	COB	Unchanged
Manager, Member Outreach, Education and Provider Relations	OC-41	COB	Unchanged

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EXHIBIT A

Position	Disclosure Category	Files With	Status
Manager, MSSP	OC-41	COB	Unchanged
Manager, Process Excellence	OC-41	COB	Unchanged
Manager, Program Implementation	OC-06	COB	Unchanged
Manager, Project Management	OC-06	COB	Unchanged
Manager, Provider Data Management Services	OC-41	COB	Unchanged
Manager, Provider Network	OC-41	COB	Unchanged
Manager, Provider Relations	OC-41	COB	Unchanged
Manager, Provider Services	OC-41	COB	Unchanged
Manager, Purchasing	OC-01	COB	Unchanged
Manager, QI Initiatives	OC-41	COB	Unchanged
Manager, Quality Analytics	OC-06	COB	Unchanged
Manager, Quality Improvement	OC-41	COB	Unchanged
Manager, Regulatory Affairs and Compliance	OC-41	COB	Unchanged
Manager, Reporting & Financial Compliance	OC-01	COB	Unchanged
Manager, Strategic Development	OC-41	COB	Unchanged
Manager, Strategic Operations	OC-41	COB	Unchanged
Manager, Systems Development	OC-08	COB	Unchanged
Manager, Utilization Management	OC-06	COB	Unchanged
Medical Case Manager	OC-41	COB	Unchanged
Medical Case Manager (LVN)	OC-41	COB	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Medical Director	OC-01	COB	Unchanged
Medical Services Case Manager	OC-41~~OC-01~~	COB	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Nurse Practitioner (PACE)	OC-41~~OC-01~~	COB	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
OneCare Operations Manager	OC-41	COB	Unchanged
Pharmacy Resident	OC-20	COB	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			

Conflict of Interest Code
EXHIBIT A

Position	Disclosure Category	Files With	Status
Pharmacy Services Specialist	OC-20	COB	Unchanged
Pharmacy Services Specialist, Int.	OC-20	COB	Unchanged
Pharmacy Services Specialist, Sr.	OC-20	COB	Unchanged
Policy Advisor, Sr.	OC-41-	COB-	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Privacy Manager	OC-41-	COB-	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Privacy Officer	OC-41-	COB-	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Process Excellence Manager	OC-41-	COB-	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Program Manager	OC-06	COB	Unchanged
Program Manager Sr.	OC-06	COB	Unchanged
Project Manager	OC-06	COB	Unchanged
Project Manager, Lead	OC-06	COB	Unchanged
Project Manager, Sr.	OC-06	COB	Unchanged
QI Nurse Specialist (RN or LVN)	OC-06	COB	Unchanged
Regulatory Affairs and Compliance Analyst	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Analyst Sr	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Lead	OC-41	COB	Unchanged
RN (PACE)	OC-41-	COB-	Added- New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Security Officer	OC-41-	COB-	Added- New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Senior Manager, Government Affairs	OC-06	COB	Unchanged
Special Counsel	OC-01	COB	Unchanged
Sr. Director Regulatory Affairs and Compliance	OC-01	COB	Unchanged
Sr. Manager Financial Analysis	OC-01	COB	Unchanged
~~Sr Manager Government Affairs~~	-	-	Deleted 20201203

Conflict of Interest Code
EXHIBIT A

Position	Disclosure Category	Files With	Status
Reason: Deleted as duplicate to Senior Manager Government Affairs			
Sr. Manager Human Resources	OC-11	COB	Unchanged
Sr. Manager Information Services	OC-08	COB	Unchanged
Sr. Manager Provider Network	OC-41	COB	Unchanged
Staff Attorney	OC-01	COB	Unchanged
Staff Attorney, Sr.	OC-01	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Supervisor, Accounting	OC-01	COB	Unchanged
Supervisor, Audit and Oversight	OC-01	COB	Unchanged
Supervisor, Behavioral Health	OC-41	COB	Unchanged
Supervisor, Budgeting	OC-01	COB	Unchanged
Supervisor, Case Management	OC-41	COB	Unchanged
Supervisor, Claims	OC-06	COB	Unchanged
Supervisor, Coding Initiatives	OC-06	COB	Unchanged
Supervisor, Credentialing	OC-41	COB	Unchanged
Supervisor, Customer Service	OC-06	COB	Unchanged
Supervisor, Data Entry	OC-06	COB	Unchanged
Supervisor, Day Center (PACE)	OC-06	COB	Unchanged
~~Supervisor, Disease Management~~ Supervisor, Population Health Management	OC-41	COB	Title change 20200903
Reason: Title changed due to change in department name			
Supervisor, Dietary Services (Pace)	OC-41	COB	Unchanged
Supervisor, Encounters	OC-06	COB	Added-New 20200903
Reason: Adding new position/category with job duties requiring completion of Form700 to the designated filer's list			
Supervisor, Facilities	OC-41	COB	Unchanged
Supervisor, Finance	OC-01	COB	Unchanged
Supervisor, Grievance and Appeals	OC-41	COB	Unchanged
Supervisor, Health Education	OC-06	COB	Unchanged
Supervisor, Information Services	OC-08	COB	Unchanged
Supervisor, Long Term Support Services	OC-41	COB	Unchanged

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Conflict of Interest Code
EXHIBIT A

Position	Disclosure Category	Files With	Status
Supervisor Member Outreach and Education	OC-06	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form700 to the designated filer's list			
Supervisor, MSSP	OC-06	COB	Unchanged
Supervisor, Nursing Services (PACE)	OC-41	COB	Unchanged
Supervisor, OneCare Customer Service	OC-06	COB	Unchanged
Supervisor, Payroll	OC-06	COB	Unchanged
Supervisor, Pharmacist	OC-20	COB	Unchanged
Supervisor, Provider Enrollment	OC-06	COB	Unchanged
Supervisor, Provider Relations	OC-41	COB	Unchanged
Supervisor, Quality Analytics	OC-06	COB	Unchanged
Supervisor, Quality Improvement	OC-41	COB	Unchanged
Supervisor, Regulatory Affairs and Compliance	OC-41~~OC-06~~	COB	Unchanged
Supervisor, Social Work (PACE)	OC-41	COB	Unchanged
Supervisor, Systems Development	OC-08	COB	Unchanged
Supervisor, Therapy Services (PACE)	OC-41	COB	Unchanged
Supervisor, Utilization Management	OC-06	COB	Unchanged

Total: 221

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code, but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB
Chief Executive Officer	Files with	COB
Chief Financial Officer	Files with	COB
Member of the Board of Directors	Files with	COB

Conflict of Interest Code
EXHIBIT A

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B

Entity: **Other Misc. Authorities, Districts and Commissions**
Agency: **CalOptima**

Disclosure Category	Disclosure Description	Status
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*..	Unchanged
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).	Unchanged
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.	Unchanged
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.	Unchanged
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.	Unchanged
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.	Unchanged
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.	Unchanged

Disclosure Descriptions
EXHIBIT B

Disclosure Category	Disclosure Description	Status
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged

Grand Total: 9

Conflict of Interest Code
EXHIBIT A

Entity: **Other Misc. Authorities, Districts and Commissions**
Agency: **CalOptima**

Position	Disclosure Category	Files With
Assistant Director	OC-41	COB
Associate Director, Customer Service	OC-41	COB
Associate Director, Information Services	OC-08	COB
Associate Director, Provider Network	OC-41	COB
Buyer	OC-01	COB
Buyer, Int.	OC-01	COB
Buyer, Sr.	OC-01	COB
Chief Counsel	OC-01	COB
Chief Executive Officer	OC-01	COB
Chief Financial Officer	OC-01	COB
Chief Information Officer	OC-01	COB
Chief Medical Officer	OC-01	COB
Chief Operating Officer	OC-01	COB
Clerk of the Board	OC-06	COB
Clinical Pharmacist	OC-20	COB
Consultant	OC-01	Agency
Contract Administrator	OC-06	COB
Contracts Manager	OC-06	COB
Contracts Manager, Sr.	OC-06	COB
Contracts Specialist	OC-06	COB
Contracts Specialist, Int.	OC-06	COB
Contracts Specialist, Sr.	OC-06	COB
Controller	OC-01	COB
Deputy Chief Counsel	OC-01	COB
Deputy Chief Medical Officer	OC-01	COB
Deputy Clerk of the Board	OC-01	COB
Director, Accounting	OC-01	COB
Director, Applications Management	OC-08	COB

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Position	Disclosure Category	Files With
Director, Audit and Oversight	OC-01	COB
Director, Behavioral Health Services	OC-41	COB
Director, Budget & Procurement	OC-01	COB
Director, Business Development	OC-41	COB
Director, Business Integration	OC-41	COB
Director, Case Management	OC-41	COB
Director, Claims Administration	OC-41	COB
Director, Clinical Outcomes	OC-01	COB
Director, Clinical Pharmacy	OC-01	COB
Director, Coding Initiatives	OC-06	COB
Director, Communications	OC-13	COB
Director, Community Relations	OC-41	COB
Director, Configuration & Coding	OC-06	COB
Director, Contracting	OC-01	COB
Director, COREC	OC-08	COB
Director, Customer Service	OC-41	COB
Director, Electronic Business	OC-06	COB
Director, Enterprise Analytics	OC-06	COB
Director, Facilities	OC-41	COB
Director, Finance & Procurement	OC-01	COB
Director, Financial Analysis	OC-01	COB
Director, Financial Compliance	OC-01	COB
Director, Fraud, Waste & Abuse and Privacy	OC-01	COB
Director, Government Affairs	OC-41	COB
Director, Grievance & Appeals	OC-41	COB
Director, Health Services	OC-41	COB
Director, Human Resources	OC-11	COB
Director, Information Services	OC-08	COB
Director, Long Term Support Services	OC-41	COB
Director, Medi-Cal Plan Operations	OC-41	COB

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Position	Disclosure Category	Files With
Director, Network Management	OC-41	COB
Director, OneCare Operations	OC-41	COB
Director, Organizational Training & Education	OC-11	COB
Director, PACE Program	OC-41	COB
Director, Population Health Management	OC-41	COB
Director, Process Excellence	OC-41	COB
Director, Program Implementation	OC-41	COB
Director, Project Management	OC-41	COB
Director, Provider Data Quality	OC-41	COB
Director, Provider Services	OC-41	COB
Director, Public Policy	OC-41	COB
Director, Quality (LTSS)	OC-41	COB
Director, Quality Analytics	OC-06	COB
Director, Quality Improvement	OC-41	COB
Director, Regulatory Affairs and Compliance	OC-01	COB
Director, Strategic Development	OC-41	COB
Director, Systems Development	OC-08	COB
Director, Utilization Management	OC-41	COB
Director, Vendor Management	OC-01	COB
Enterprise Analytics Manager	OC-06	COB
Executive Director, Behavioral Health Integration	OC-41	COB
Executive Director, Clinical Operations	OC-01	COB
Executive Director, Compliance	OC-01	COB
Executive Director, Human Resources	OC-01	COB
Executive Director, Network Operations	OC-01	COB
Executive Director, Operations	OC-01	COB
Executive Director, Program Implementation	OC-01	COB
Executive Director, Public Affairs	OC-01	COB
Executive Director, Quality & Population Health Management	OC-01	COB
Financial Analyst	OC-01	COB

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Position	Disclosure Category	Files With
Financial Analyst, Sr.	OC-01	COB
Financial Reporting Analyst	OC-01	COB
Litigation Support Specialist	OC-41	COB
Manager, Accounting	OC-01	COB
Manager, Actuary	OC-01	COB
Manager, Applications Management	OC-08	COB
Manager, Audit and Oversight	OC-01	COB
Manager, Behavioral Health	OC-41	COB
Manager, Business Integration	OC-06	COB
Manager, Case Management	OC-41	COB
Manager, Claims	OC-41	COB
Manager, Clinic Operations	OC-06	COB
Manager, Clinical Pharmacists	OC-20	COB
Manager, Coding Quality	OC-06	COB
Manager, Communications	OC-13	COB
Manager, Community Relations	OC-06	COB
Manager, Contracting	OC-41	COB
Manager, Creative Branding	OC-13	COB
Manager, Cultural & Linguistics	OC-06	COB
Manager, Customer Service	OC-41	COB
Manager, Decision Support	OC-06	COB
Manager, Electronic Business	OC-06	COB
Manager, Employment Services	OC-11	COB
Manager, Encounters	OC-06	COB
Manager, Environmental Health & Safety	OC-06	COB
Manager, Facilities	OC-41	COB
Manager, Finance	OC-01	COB
Manager, Financial Analysis	OC-01	COB
Manager, Government Affairs	OC-41	COB
Manager, Grievance and Appeals	OC-41	COB

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Position	Disclosure Category	Files With
Manager, Health Education	OC-41	COB
Manager, HEDIS	OC-06	COB
Manager, Human Resources	OC-11	COB
Manager, Information Services	OC-08	COB
Manager, Information Technology	OC-08	COB
Manager, Integration Government Liaison	OC-41	COB
Manager, Long Term Support Services	OC-41	COB
Manager, Marketing and Enrollment (PACE)	OC-06	COB
Manager, Marketing & Outreach	OC-06	COB
Manager, Medical Data Management	OC-06	COB
Manager, Medi-Cal Program Operations	OC-41	COB
Manager, Member Liaison Program	OC-41	COB
Manager, Member Outreach & Education	OC-41	COB
Manager, Member Outreach, Education and Provider Relations	OC-41	COB
Manager, MSSP	OC-41	COB
Manager, Population Health Management	OC-41	COB
Manager, Process Excellence	OC-41	COB
Manager, Program Implementation	OC-06	COB
Manager, Project Management	OC-06	COB
Manager, Provider Data Management Services	OC-41	COB
Manager, Provider Network	OC-41	COB
Manager, Provider Relations	OC-41	COB
Manager, Provider Services	OC-41	COB
Manager, Purchasing	OC-01	COB
Manager, QI Initiatives	OC-41	COB
Manager, Quality Analytics	OC-06	COB
Manager, Quality Improvement	OC-41	COB
Manager, Regulatory Affairs and Compliance	OC-41	COB
Manager, Reporting & Financial Compliance	OC-01	COB
Manager, Strategic Development	OC-41	COB

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Position	Disclosure Category	Files With
Manager, Strategic Operations	OC-41	COB
Manager, Systems Development	OC-08	COB
Manager, Utilization Management	OC-06	COB
Medical Case Manager	OC-41	COB
Medical Case Manager (LVN)	OC-41	COB
Medical Director	OC-01	COB
Medical Services Case Manager	OC-41	COB
Nurse Practitioner (PACE)	OC-41	COB
OneCare Operations Manager	OC-41	COB
Pharmacy Resident	OC-20	COB
Pharmacy Services Specialist	OC-20	COB
Pharmacy Services Specialist, Int.	OC-20	COB
Pharmacy Services Specialist, Sr.	OC-20	COB
Policy Advisor, Sr.	OC-41	COB
Privacy Manager	OC-41	COB
Privacy Officer	OC-41	COB
Process Excellence Manager	OC-41	COB
Program Manager	OC-06	COB
Program Manager, Sr.	OC-06	COB
Project Manager	OC-06	COB
Project Manager, Lead	OC-06	COB
Project Manager, Sr.	OC-06	COB
QI Nurse Specialist (RN or LVN)	OC-06	COB
Regulatory Affairs and Compliance Analyst	OC-41	COB
Regulatory Affairs and Compliance Analyst, Sr.	OC-41	COB
Regulatory Affairs and Compliance, Lead	OC-41	COB
RN (PACE)	OC-41	COB
Security Officer	OC-41	COB
Senior Manager, Government Affairs	OC-06	COB
Special Counsel	OC-01	COB

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EXHIBIT A

Position	Disclosure Category	Files With
Sr. Director, Regulatory Affairs and Compliance	OC-01	COB
Sr. Manager, Financial Analysis	OC-01	COB
Sr. Manager, Human Resources	OC-11	COB
Sr. Manager, Information Services	OC-08	COB
Sr. Manager, Provider Network	OC-41	COB
Staff Attorney	OC-01	COB
Staff Attorney, Sr.	OC-01	COB
Supervisor, Accounting	OC-01	COB
Supervisor, Audit and Oversight	OC-01	COB
Supervisor, Behavioral Health	OC-41	COB
Supervisor, Budgeting	OC-01	COB
Supervisor, Case Management	OC-41	COB
Supervisor, Claims	OC-06	COB
Supervisor, Coding Initiatives	OC-06	COB
Supervisor, Credentialing	OC-41	COB
Supervisor, Customer Service	OC-06	COB
Supervisor, Data Entry	OC-06	COB
Supervisor, Day Center (PACE)	OC-06	COB
Supervisor, Dietary Services (PACE)	OC-41	COB
Supervisor, Encounters	OC-06	COB
Supervisor, Facilities	OC-41	COB
Supervisor, Finance	OC-01	COB
Supervisor, Grievance and Appeals	OC-41	COB
Supervisor, Health Education	OC-06	COB
Supervisor, Information Services	OC-08	COB
Supervisor, Long Term Support Services	OC-41	COB
Supervisor, Member Outreach and Education	OC-06	COB
Supervisor, MSSP	OC-06	COB
Supervisor, Nursing Services (PACE)	OC-41	COB
Supervisor, OneCare Customer Service	OC-06	COB

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Position	Disclosure Category	Files With
Supervisor, Payroll	OC-06	COB
Supervisor, Pharmacist	OC-20	COB
Supervisor, Population Health Management	OC-41	COB
Supervisor, Provider Enrollment	OC-06	COB
Supervisor, Provider Relations	OC-41	COB
Supervisor, Quality Analytics	OC-06	COB
Supervisor, Quality Improvement	OC-41	COB
Supervisor, Regulatory Affairs and Compliance	OC-41	COB
Supervisor, Social Work (PACE)	OC-41	COB
Supervisor, Systems Development	OC-08	COB
Supervisor, Therapy Services (PACE)	OC-41	COB
Supervisor, Utilization Management	OC-06	COB

Total: 221

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code, but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB
Chief Executive Officer	Files with	COB
Chief Financial Officer	Files with	COB
Member of the Board of Directors	Files with	COB

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B

Entity: **Other Misc. Authorities, Districts and Commissions**
Agency: **CalOptima**

Disclosure Category	Disclosure Description
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*..
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.

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Disclosure Category	Disclosure Description
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.

Grand Total: 9

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

14. Consider a New Letter of Commitment for Medi-Cal Supportive Services in Connection with a Grant Award to American Family Housing under the Housing for a Healthy California Program

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Candice Gomez, Executive Director, Program Implementation, (714) 246-8849
Debra Kegel, Director, Strategic Development, (714) 347-5763

Recommended Actions

Authorize the Chief Executive Officer to issue a new letter of commitment for Medi-Cal supportive services in connection with a grant award to American Family Housing under the Housing for a Healthy California Program

Background

In September 2017, AB 74 was signed into law authorizing the California Department of Housing and Community Development to develop the Housing for a Healthy California (HHC) Program to create supportive housing opportunities through competitive grants to counties and developers. The goal of the HHC Program is to reduce the financial burden of emergency room visits, inpatient care and nursing home stays, and the use of the corrections systems and law enforcement resources as the point of entry for health care for the target population.

The target population for the HHC Program includes individuals who are:

- Chronically homeless, or homeless and high-cost health care users upon initial eligibility;
- Medi-Cal beneficiaries
- Eligible for Supplemental Security Income;
- Eligible to receive services under a program providing services promoting housing stability; and,
- Likely to improve their health conditions with supportive housing.

American Family Housing (AFH) submitted an application for development and operations of the Casa Paloma property, a 49-unit complex in Orange County, including 24 permanent supportive housing units. The application included a Supportive Services Plan (the Plan), which identified AFH as the Lead Service Provider (LSP) with overall responsibility for provision of the supportive services and for implementation of the Plan. The LSP may provide services directly or through agreement with other agencies. The application also included budget and staffing information for service delivery, including from subcontractors; HHC permits the budget to include the value of in-kind services that might be provided, for example, by a Medi-Cal Managed Care Plan, including Health Homes Programs (HHP).

On August 1, 2019, the CalOptima Board of Directors approved issuance of a letter of commitment in connection with the AFH application for participation in the HHC Program.
The letter issued by CalOptima included the in-kind value of services that CalOptima would provide for its members. The letter stated that CalOptima's responsibility would include services that are provided under its contracts with the Department of Health Care Services (DHCS), such as providing access to

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primary, preventive and specialty care for all tenants who are CalOptima members, including enhanced services for HHP-enrolled members. AFH and CalOptima contemplated a Memorandum of Understanding (MOU) describing how AFH and CalOptima would coordinate services for CalOptima members residing at Casa Paloma and participating in the HHC Program; AFH had initially advised that the MOU would be required in early 2021.

Discussion

Since that time, AFH has advised that funding has been secured for the development of the Casa Paloma property that is now expected to include 69 affordable housing units, of which 34 will be permanent supportive housing units funded under HHC. Additionally, AFH has advised that the MOU will not be required until late 2022 when the property is ready for occupancy.

In lieu of the MOU, and in light of the increased number of HHC permanent supportive housing units, AFH has asked for CalOptima to issue a new letter of commitment that will supersede the previous letter. The request is that the updated letter will:

- Adjust the projected annual estimate of in-kind support for Medi-Cal Covered Services and HHP services to eligible Medi-Cal members;
- Reiterate that CalOptima's obligations will include only services required under its DHCS contracts; and,
- Reflect that services will be limited to CalOptima Medi-Cal members, including those in HHP (or successor program).

CalOptima staff will return to the Board at a future meeting to seek authority to enter into the MOU, if needed.

Fiscal Impact

Management does not anticipate an additional fiscal impact for the proposed participation in the HHC Program. Services provided under the HHC Program will be limited to medically necessary covered services for CalOptima enrolled Medi-Cal members. To the extent that there is any fiscal impact due to increases in required resources, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation

CalOptima and AFH share common goals of improving care and health outcomes for residents of Orange County, including members experiencing homelessness. Providing a new letter of commitment will support AFH as it continues development of the property intended to increase opportunities for CalOptima members who are chronically homeless or high-cost health utilizers, including those who may be eligible or enrolled in HHP.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated August 1, 2019, Consider Medi-Cal Supportive Services Participation in the Housing for Healthy California Program

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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Attachment to the December 3, 2020 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
American Family Housing	15161 Jackson Street	Midway City	CA	92655
AFH Casa Paloma LP	15161 Jackson Street	Midway City	CA	92655

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Medi-Cal Supportive Services Participation in the Housing for Healthy California Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. With respect to the Grant application submitted by AFH Casa Paloma LP and by other developer applicants under Article I of the Department of Housing and Community Development Housing for Healthy California (HHC) Program, authorize the Chief Executive Officer (CEO) to provide such applicants whose target populations include CalOptima Medi-Cal Members with a letter of commitment for Medi-Cal supportive services in conjunction with their proposed participation for the program;
2. With respect to the Grant application submitted by the Orange County Health Care Agency (HCA) under Article II of the Department of Housing and Community Development Housing for Healthy California (HHC) Program:
   A. Authorize the CEO to provide HCA with a letter of commitment for Medi-Cal supportive services participation for the program; and,
   B. Authorize the CEO, with the assistance of Legal Counsel, to enter into a Memorandum of Understanding (MOU) with HCA to coordinate Supportive Services and information exchange activities.

Rev. 8/1/19

Background

In September 2017, AB 74 was signed into law authorizing the California Department of Housing and Community Development (HCD) to develop the Housing for Healthy California (HHC) Program to create supportive housing opportunities through competitive grants to counties and developers. The goal of the HHC Program is to reduce the financial burden of emergency room visits, inpatient care and nursing home stays and use of corrections systems and law enforcement resources as the point of health care for people who are chronically homeless or are homeless and high-cost health care users.

On May 13, 2019, HCD released final guidance and Notice of Funding Availability (NOFA), including application requirements for two funding opportunities under:

- Article I: for property owners or developers for operating reserve grants and capital loans using National Housing Trust Fund allocations; and

- Article II: for counties to acquire, newly construct, or reconstruct and rehabilitate homes, as well as for rental subsidies and rental assistance for existing and new supportive

housing opportunities. For this purpose, "county" means a county, city and county or a city collaborating with a county to secure services funding.

The target population to be served under both Articles I and II is a person who is:

- Chronically homeless or is homeless and high-cost health care users upon initial eligibility;
- A Medi-Cal beneficiary;
- Eligible for Supplemental Security Income;
- Eligible to receive services under a program providing services promoting housing stability; and,
- Likely to improve his or her health conditions with Supportive housing.

A Supportive Services Plan (the Plan) must be submitted with applications under Articles I and II. The Plan describes the supportive services provided for those eligible for HHC Program and identifies the Lead Service Provider (LSP) with overall responsibility for provision of the supportive services and for implementation of the Plan. Supportive Services are defined as social, health, educational, income support and employment services and benefits, coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits. The LSP may provide services directly or through agreement with other agencies. The LSP must have at least three or more years of experience serving members in the target population, including comprehensive case management in supportive housing.

The application under Article I must also include a Memorandum of Understanding (MOU) or commitment letter from the Lead Service Provider or county department to make available to the project's HHC tenants case management and supportive services from one of the following:

- County's Whole Person Care (WPC) Pilot;
- Health Homes Program (HHP);
- Managed care organization (MCO); or,
- Other community-based health care services.

The Application under Article II requires identified funding sources for providing intensive services promoting housing sustainability including, for example:

- County general funds;
- WPC pilot program funds, to the extent those funds are available, or the WPC program has been renewed;
- HHP;
- MHSA program;
- MCO; or,
- Other County-controlled funding to provide these services to eligible participants.

The application under Articles I and II require budget and staffing information for service delivery, including from subcontractors, which may include in-kind services that might be

provided, for example, by an MCO and HHP programs. The applications are due August 13, 2019.

Discussion

Orange County Community Resources and HCA (jointly the County) have taken a leadership role for planning and supporting development of applications by an owner or developer under Article I, and by HCA under Article II, as well as for Supportive Services Plan development under Article II. Collaboration between CalOptima and County on the HHC Program began in March 2019.

Article I

AFH Casa Paloma LP is expected to submit an application under Article I for development of a 49-unit complex of which will 24 will be supportive housing units (Development). AFH Casa Loma LP has advised that its affiliate, American Family Housing, Inc. a 501(c) (3) organization, will be the LSP for the Development. The application will include the Supportive Services Plan outlining the roles and responsibilities of the LSP, HCA, and CalOptima; CalOptima's responsibility will include services that are required of it under its DHCS contracts, such as providing access to primary, preventive and specialty care for all tenants who are CalOptima members and, for HHP enrolled members, housing navigation services and tenancy support services. Thus, CalOptima's participation will be limited to CalOptima Medi-Cal Members, including those in HHP and to Medi-Cal covered services. AFC Casa Loma LP has requested CalOptima provide a letter of commitment to satisfy the application requirements. CalOptima anticipates that any other applicant under Article I would make a similar request. Additionally, AFS Casa Loma has requested that CalOptima enter into a Memorandum of Understanding (MOU) with its LSP prior to the first tenancy if it is awarded an HHC grant; the first tenancy is not expected until at least 2021. CalOptima staff will return to the Board at a future meeting to seek authority to enter the MOU, if needed.

Article II

The HCA has advised that it intends, subject to Board of Supervisors approval, to submit an application under Article II for funding for housing subsidies for 214 individuals. CalOptima staff and the County have reviewed the application requirements, as well as their respective experience with the target population. They also discussed the HCA led Whole Person Care pilot, under the Department of Health Care Services (DHCS) Medi-Cal 2020 waiver program; discussions included CalOptima's on-going participation in WPC, the current December 31, 2020 waiver expiration date and HCA's planned development of a sustainability plan to continue services following termination of the WPC pilot.

CalOptima staff has shared information about the anticipated implementation of HHP on January 1, 2020, subject to DHCS approval. CalOptima staff and the County have also reviewed the overlapping target populations and services under their various respective programs. It has been noted that some potential tenants may not be CalOptima Medi-Cal members (either initially or during their tenancy), and that many of the specific services (e.g., peer support, recreational and social activities) are not covered services under CalOptima's Medi-Cal Agreement with DHCS,

and some services will be covered only for members enrolled in HHP (e.g., housing navigation and tenancy support services). Thus, CalOptima's participation will be limited to CalOptima Medi-Cal Members, including those in HHP and to Medi-Cal covered services.

CalOptima staff and the County additionally reviewed the application requirements, particularly related scoring based on experience in providing supportive housing services. In order to provide the strongest possible application, HCA is expected to be the LSP under Article II. The application will include the Supportive Services Plan outlining the roles and responsibilities of the LSP and CalOptima. HCA has requested CalOptima provide a letter of commitment to satisfy the application requirements. Additionally, HCA has asked that CalOptima enter into an MOU, should HCA be awarded an HHC grant. Similar to Article I, CalOptima's responsibility will be consistent with its responsibilities under its DHCS Medi-Cal contract.

Fiscal Impact
Management does not anticipate an additional fiscal impact for the proposed participation in the HHC Program. Services provided under the HHC Program will be limited to Covered Services for CalOptima enrolled Medi-Cal Members. To the extent there is any fiscal impact due to increases in required resources, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation
CalOptima, County and American Family Housing share common goals of improving care and health outcomes for residents of Orange County, including members experiencing homelessness. HHC provides increased opportunities for CalOptima members who are chronically homeless or high-cost health utilizers, including those who may be eligible or enrolled in HHP and/or WPC.

Concurrence
Gary Crockett, Chief Counsel

Attachments
California Department of Housing and Community Development Housing for Healthy California Final Guidelines amended May 13, 2019

/s/ Michael Schrader *7/24/2019*
Authorized Signature **Date**

Housing for a Healthy California (Chapter 777, Statutes of 2017)
Final Guidelines Amended

State of California
Gavin Newsom, Governor

Alexis Podesta, Secretary
Business, Consumer Services and Housing Agency

Ben Metcalf, Director
Department of Housing and Community Development

2020 West El Camino Avenue, Suite 500
Sacramento, CA 95833

Telephone: (916) 263-2771
Website: http://www.hcd.ca.gov
HHC email: HousingforHealthyCA@hcd.ca.gov

January 25, 2019
Amended May 13, 2019

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The matters set forth herein are regulatory mandates, and are adopted in accordance with the authorities set forth below:

> Quasi-legislative regulations … have the dignity of statutes … [and]… delegation of legislative authority includes the power to elaborate the meaning of key statutory terms…
>
> *Ramirez v. Yosemite Water Co.*, 20 Cal. 4th 785, 800 (1999)
>
> Any regulations or guidelines that are adopted, amended, or repealed to implement this part shall not be subject to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
>
> Health and Safety Code Section 53598, subdivision (b).

INTRODUCTION

The Housing for a Healthy California (HHC) Program provides funding that allows the California Department of Housing and Community Development (Department) to provide Supportive housing opportunities through grants to Counties for capital and operating assistance, or operating reserve grants and capital loans to developers on a competitive basis. The guidelines for the Program are organized into two Articles as follows:

Article I. National Housing Trust Fund Allocation. This section includes Program definitions and requirements pursuant to the federal National Housing Trust Fund (NHTF) allocations. The Department will allocate these NHTF funds competitively to developers for operating reserve grants and capital loans.

Article II. Building Homes and Jobs Trust Fund Allocation. This section includes Program definitions and requirements pursuant to SB 2 Building Homes and Jobs Act. The Department will utilize a portion of monies collected in calendar year 2018 and deposited into the Building Homes and Jobs Trust Fund for the HHC program. The Department will allocate these funds competitively to counties for acquisition, new construction, reconstruction, rehabilitation, administrative costs, capitalized operating subsidy reserves (COSR), and rental subsidies and rental assistance for existing and new Supportive housing opportunities to assist the HHC program's Target Population.

A Notice of Funding Availability (NOFA) will be released for each Article as funds are available.

Housing for a Healthy California Program Final Guidelines

Article I. National Housing Trust Fund Allocation

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Article II. Building Homes and Jobs Trust Fund Allocation

Article I. National Housing Trust Fund Allocation

Section 100. Purpose and Scope

(a) In September of 2017, AB 74 was signed into law. This legislation authorizes the California Department of Housing and Community Development (Department) to develop the Housing for a Healthy California (HHC) Program to create Supportive housing for individuals who are recipients of or eligible for health care provided through the California Department of Health Care Services (DHCS) Medi-Cal program. The goal of the HHC program is to reduce the financial burden on local and state resources due to the overutilization of emergency departments, inpatient care, nursing home stays and use of corrections systems and law enforcement resources as the point of health care provision for people who are Chronically homeless or Homeless and a High-cost health user. The Department shall coordinate with the DHCS, consistent with state and federal privacy laws, to match program participant data to Medi-Cal data to identify outcomes among participants as well as changes in health care costs and utilization associated with housing and services provided under HHC.

(b) AB 74 directs the Department to utilize federal National Housing Trust Fund (NHTF) allocations for years 2018 - 2021 for the HHC program. Starting in August 2018, and for the next three years, the Department must submit a federal NHTF allocation plan that aligns with federal NHTF and AB 74 requirements. The Department will allocate these NHTF funds competitively to developers for operating reserve grants and capital loans.

In addition to applicable state and federal laws and regulations, these guidelines (hereinafter “Guidelines”) implement, interpret, and make specific the HHC authorized by Part 14.2 (commencing with Section 53590) of Division 31 of the Health and Safety Code.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 101. Definitions

All terms not defined below shall, unless their context suggests otherwise, be interpreted in accordance with the meaning of terms described in Part 14.2 of Division 31 of the Health and Safety Code (commencing with Section 53590).

(a) “Applicant” means an organization, agency, or other entity (including a public housing agency, a for-profit entity, or a nonprofit entity) that is an owner or developer as defined by 24 CFR 93.2.

(b) “Area Median Income” or “AMI” means the most recent applicable county median family income published by the U.S. Department of Housing and Urban Development (HUD).

(c) “Assisted Unit” means a housing unit that is subject to the NHTF rent and/or occupancy restrictions as a result of the financial assistance provided under the program.

(d) “Case Manager” means a social worker or other qualified individual who works with a tenant to offer individualized service planning that is flexible and creative to help the tenant gain housing stability. It includes working in collaboration with the tenant to plan, assess, coordinate, and reassess the tenant’s needs, as well as providing referrals and advocacy, and connecting to community support to meet tenants’ supportive service needs. Services include, but are not limited to: tenancy support services, coordination of medical and behavioral health, and substance use disorder treatment, employment services, life skills training, peer support, and crisis management interventions. Resident service coordinators are not Case Managers.

(e) “Chronically homeless” has the same meaning as in Part 91.5 and 578.3 of Title 24 of the Code of Federal Regulations, except that people who were Chronically homeless before entering an institution would continue to be defined as Chronically homeless before discharge, regardless of length of stay, as those parts read on January 1, 2018.

(f) “Continuum of Care” has the same meaning as 24 CFR Section 578.3.

(g) “Coordinated Entry System” or “CES” means a centralized or coordinated process developed pursuant to 24 CFR Section 578.7(a)(8) designed to coordinate program participant intake, assessment, and referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

(h) “Department” means the California Department of Housing and Community Development.

(i) Development Sponsor or “Sponsor”, as defined in Section 50675.2 of the Health and Safety Code and subdivision (c) of Section 50669 of the Health and Safety Code, means any individual, joint venture, partnership, limited partnership, trust, corporation, cooperative, local public entity, duly constituted governing body of an Indian Reservation or Rancheria, or other legal entity, or any combination thereof, certified by the Department as qualified to own, manage, and rehabilitate a rental housing development. A Development Sponsor may be organized for profit, limited profit or be nonprofit, and includes a limited partnership in which the Development Sponsor or an affiliate of the Development Sponsor is a general partner.

(j) “Distributions” has the same meaning as under 25 CCR Section 8301.

(k) “Extremely Low Income” or “ELI” has the same meaning as in 24 CFR 93.2.

(l) “Federal Housing Trust Fund” has the same meaning as the National Housing Trust Fund (NHTF) established pursuant to the Housing and Economic Recovery Act of 2008 (Public Law 110-289) and implementing federal regulations.

(m)"Fiscal Integrity" means, for any project for any given period of time during the term specified in the Program's regulatory agreement, that the total Operating Income for such project for such period of time, plus funds released pursuant to the Program documents from the project's operating reserve account(s) during such period of time is sufficient to: (1) pay all current Operating Expenses for such project for such period of time; (2) pay all current mandatory debt service (excluding deferred interest) coming due with respect to such project for such period of time; (3) fully fund all reserve accounts established pursuant to the Program documents for such project for such period of time; and (4) pay other costs permitted by the Program documents for such project for such period of time. The ability to pay any or all the permitted annual distributions for a project shall not be considered in determining the Fiscal Integrity of a project.

(n) "HHC" means the Housing for a Healthy California Program administered by the Department.

(o) "High-cost health users" mean people who have had either at least three emergency department visits or one hospital inpatient stay over the last year.

(p) "Homeless" has the same meaning as in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018.

(q) "Housing First" has the same meaning as in Welfare and Institutions Code Section 8255.

(r) "HUD" means the federal U.S. Department of Housing and Urban Development.

(s) "Lead Service Provider" or "LSP" means the organization that has the overall responsibility for the provisions of Supportive Services and implementation of the Supportive Services plan. The LSP may directly provide comprehensive case management services or contract with other agencies that provide services.

(t) "NOFA" means a Notice of Funding Availability.

(u) "Operating Expense" has the same meaning as in 25 CCR Section 8301.

(v) "Operating Income" has the same meaning as in 25 CCR Section 8301.

(w) "Operating Cost Assistance Reserves" has the same meaning as in 24 CFR Section 93.201(e).

(x) "Permanent housing" means a housing unit where the landlord does not limit length of stay in the housing unit, the landlord does not restrict the movements of the tenant, and the tenant has a lease and is subject to the rights and responsibilities of tenancy, pursuant to Chapter 2 (commencing with Section 1940) of Title 5 of Part 4 of Division 3 of the Civil Code.

(y) "Point in Time Count" or "PIT" refers to an annual count of sheltered and unsheltered homeless persons on a single night in January.

(z) “Program” means the Housing for a Healthy California Program.

(aa) “Project Team” consists of the Applicant, the Lead Service Provider, and the property manager.

(bb) “Recipient” means an Applicant who has been awarded NHTF funds and has the same meaning as in 24 CFR 93.2. A Recipient must:

(1) Make acceptable assurances that it will comply with all NHTF requirements during the entire affordability period;

(2) Demonstrate ability and financial capacity to undertake, comply, and manage the eligible activity;

(3) Demonstrate familiarity with requirements of state, federal, and any other housing programs used in conjunction with NHTF funds to ensure compliance; and

(4) Demonstrate experience and capacity to conduct the eligible NHTF activity in question as evidenced by relevant history.

(cc) “Rural Area” has the same meaning as in Section 50199.21 of the California Health and Safety Code.

(dd) “Supportive housing” means housing with no limit on length of stay, that is occupied by the Target Population and that is linked to onsite or offsite services that assist the Supportive housing resident in retaining the housing, improving his/her health status, and maximize his/her ability to live, and when possible, work in the community.

(ee) “Supportive Services” means social, health, educational, income support and employment services and benefits, coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits.

(ff) “Target Population” means a person who is Chronically homeless or is Homeless and a High-cost health user upon initial eligibility, is a Medi-Cal beneficiary, is eligible for Supplemental Security Income, is eligible to receive services under a program providing services promoting housing stability, and is likely to improve his or her health conditions with Supportive housing.

(gg) “TCAC” means California Tax Credit Allocation Committee.

(hh) “UMR” means the Uniform Multifamily Regulations commencing with 25 CCR Section 8300.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53590 and 53595.

Section 102. Minimum Requirements

The Applicant shall comply with the requirements of HHC and all applicable federal and state laws. To be eligible to receive funding, projects must meet all the following minimum requirements:

(a) Eligible Applicants.

(1) Owners or developers that meet the Recipient definition in 24 CFR 93.2.

(2) Applicant with no members of the development team currently federally debarred or suspended.

(b) Financial Feasibility. The project shall meet the requirements of Sections 105 and 106 and must prove Fiscal Integrity.

(c) Experience. Collectively, among the members of the Project Team, all the following minimum experience requirements must be met:

(1) Development, ownership, or operation of at least two permanent Supportive housing projects or at least two affordable rental housing projects in the last five years.

(2) The Lead Service Provider, which may be the county, or a qualified contracted agency, shall have three or more years of experience serving persons who qualify as members of the Target Population and includes comprehensive case management in Supportive housing, and can include scattered site housing.

(3) The property manager shall have three or more years of experience serving persons who qualify as members of the Target Population in Supportive housing.

(4) Experience must be documented through contracts with public agencies, housing owners, or foundations for services provided to at least 10 households at any one time in either housing projects subject to agreements with public agencies restricting rent and occupancy or through tenant-based housing assistance programs. If the Lead Service Provider is not part of the ownership entity, the Applicant must have a written agreement with the Lead Service Provider to implement the Supportive Services plan and submit this agreement along with the application for funding. Only the Lead Service Provider may enter into written agreements for services under the provisions of the Supportive Services plan. All service providers must have a written agreement with the Lead Service Provider prior to commencement of services.

(d) Site Control. The Applicant must have site control of the proposed project that meets the requirements of the UMR 25 CCR Section 8303, which requires the Applicant to have site control of the proposed project property, in the name of the Applicant or an entity controlled by the Applicant. The ownership interest may be demonstrated by fee title, a leasehold interest, an enforceable option to purchase, a disposition and

development agreement, an agreement giving the Applicant exclusive rights to negotiate for acquisition, or a land sales contract. This includes compliance (if applicable) with UMR 25 CCR Section 8316 for a leasehold interest in the property.

(e) Integration. Proposed projects must demonstrate integration of the Target Population with the general public. In order to demonstrate compliance with this requirement, the following conditions must all be met:

(1) Assisted Units must be integrated with other units in the project and not separated onto separate floors or areas of the building;

(2) To promote integration of the Target Population with other project tenants, in projects of greater than 20 units, the Department will fund no more than 49 percent of the project's total units as Assisted Units. This limitation shall not be interpreted to preclude occupancy of any project units by persons with disabilities or restrictions by other funding sources, including but not limited to TCAC, that result in more than 49 percent of the total project units being restricted to the Target Population. It shall also not apply to projects complying with alternative requirements for demonstrating Olmstead compliance adopted by local jurisdictions and approved by the Department;

(3) Applicants must certify that they will facilitate or provide regular community building activities and architectural design features that promote tenant interaction. For example, indoor and outdoor community space within the project, and wide hallways as feasible, depending on the scope of the construction activity; and

(4) The Supportive Services plan and property management plan, submitted with the application, must document policies that promote participation by tenants in community activities and impose no restriction on guests that are not otherwise required by other project funding sources or would not be common in other unsubsidized rental housing in the community.

(f) Article XXXIV. All projects shall comply with Article XXXIV Section 1 of the California Constitution, as clarified by Public Housing Election Implementation Law (H&S Code Section 37000 et seq). Article XXXIV documentation for loans underwritten by the Department shall be subject to review and approval by the Department prior to the execution of the Department's Standard Agreement.

(g) Scattered Site Housing. Projects are permitted to be on scattered sites provided that all of the below conditions are satisfied prior to the closing of the loan. The requirements of this section shall be interpreted in a manner consistent with the requirements of 25 CCR Section 8303(b) pertaining to scattered site housing.

(1) All project sites in the rental housing development must have a single owner and property manager;

(2) All project sites shall be governed by one set of Program documents, which among other things, shall include similar tenant selection criteria, serve similar

tenant populations, and have similar rent and income restrictions;

(3) If the rental housing development has an operating reserve, there shall only be one operating reserve for all sites in the project;

(4) There may be at most one lender with required payments senior to the Department's loan;

(5) There must be a single audit and annual report that covers all project sites;

(6) The Sponsor's obligations under the Department's Program documents must be secured by all project sites, with lien priority relative to local public agency lenders determined in accordance with 25 CCR Section 8315, and use of cash flow available for residual receipts loan payments determined in accordance with 25 CCR Section 8314; and

(7) The Department must be named on insurance policies covering all project sites, with coverage meeting Department requirements.

(h) Environmental Conditions. All project sites must be free from severe adverse environmental conditions, such as the presence of toxic waste that is economically infeasible to remove and that cannot be mitigated. See 24 CFR 93.301(f).

(i) Federal, State and Local Requirements. All Assisted Units and other units of the project must be on a permanent foundation and must meet all applicable federal, state, and local requirements pertaining to rental housing, including, but not limited to, requirements for minimum square footage and requirements related to maintaining the property in a safe and sanitary condition.

(j) Amenities. All project sites must involve a development site that has reasonable accessibility to public transit, public schools, public parks or other public recreational facilities, and is of reasonable proximity to services and amenities for the purposed tenant population as is typically available in that county. The development site must also be within reasonable proximity to employment opportunities available to the tenant population. The development must consider the hours that the services and amenities are available and the frequency, travel time, and cost of transportation to the tenants. The criteria used to establish reasonable accessibility and reasonable proximity are specified in Section 111(h) of the Guidelines.

(k) Stacking Unit-Based Subsidies.

(1) The Department does not allow stacking of multiple Department Development Funding Sources on an HHC Assisted Unit. Capitalized operating subsidy reserves or operating assistance is allowed for all units. The prohibition of subsidy stacking in HHC refers to the use of multiple funding sources on a single HHC-assisted unit. "Department Development Funding Sources" shall mean loan or grant funds awarded for permanent funding of development costs under the following programs:

a. Multifamily Housing Program
b. Supportive Housing Multifamily Housing Program

c. Veterans Housing and Homelessness Prevention Program
d. No Place Like Home Program, including funds awarded either by the Department or an Alternative Process County
e. Affordable Housing and Sustainable Communities Program Affordable Housing
f. Development loan, except for grants for infrastructure, transportation-related amenities and program costs
g. Transit Oriented Development Program rental housing development loan, except for grants for infrastructure
h. Joe Serna, Junior Farmworker Housing Grant Program
i. SB 2 Farmworker Housing Program
j. National Housing Trust Fund Program

(2) As an exception to this Subsection (k)(1), a previously Department-assisted unit is eligible for funding assistance from other Department programs upon re syndication, or 14 years from the Placed in Service date noted on the TCAC form 8609 (Placed in Service Package).

(l) Relocation. The Applicant of any project resulting in displacement of tenants shall be solely responsible for providing the assistance and benefits set forth in this subsection and in applicable federal, state, and local law, whichever is more stringent.

(1) All tenants of a property who are displaced as a direct result of the development of an HHC project shall be entitled to relocation benefits and assistance as provided in 24 CFR 93.352.

(2) The Applicant shall prepare a relocation plan conforming with the provisions of 24 CFR 93.352. For loans underwritten by the Department, the relocation plan or other relocation documentation shall be subject to the review and approval by the Department prior to the beginning of construction.

(m) Applicant must comply with 2 CFR Part 200.

(n) Application shall be on forms made available by the Department. In addition, applications must contain:

(1) A resolution from the Applicant's governing board to apply for NHTF funds for a requested amount that does not exceed the amount authorized.

(2) A memorandum of understanding or commitment letter from either the Lead Services Provider or a county department to make available to the project's HHC tenants case management and Supportive Services from one of the following:
a. County's Whole Person Care Pilot,
b. Health Homes Program,
c. Managed care organization, or
d. Other community-based health care services.

(3) A certification that residents of the housing development will be authorized to own or otherwise maintain one or more common household pets pursuant to the Pet Friendly Housing Act of 2017 (California Health & Safety Code, Section 50466).

(4) An initial plan for providing Supportive Services based on the anticipated needs of the Target Population proposed to be served by the project must meet the requirements outlined in Section 112.

(5) A property management plan that:
   a. Utilizes a low-barrier tenant selection process;
   b. Accepts referrals of those with the highest needs for available housing;
   c. Implements Housing First practices, consistent with the core components set forth in Welfare and Institutions Code Section 8255(b);
   d. Implements policies and practices to prevent evictions and to facilitate the implementation of reasonable accommodation policies;
   e. Implements policies and practices of trauma-informed care and harm reduction to prevent evictions; and
   f. Implements policies and practices that comply with the Violence Against Women Act (Title VI-Safe Homes for Victims of Domestic Violence, Dating Violence, Sexual Assault, and Stalking – Section 601 – 603 and 81 CFR 80724).

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 103. Uses and Terms

(a) NHTF funds will be limited to the eligible uses described in 24 CFR 93.200 and 93.201.

(1) Loans for acquisition and/or new construction.
   a. NHTF loans shall be used in accordance with 24 CFR Part 93 Subpart E.
   b. Proposed projects involving new construction and requiring the demolition of existing residential units are eligible only if the number of bedrooms in the new project is at least equal to the total number of bedrooms in the demolished structures. The new units may exist on separate parcels provided that all parcels are part of the same project and meet the requirements of scattered site housing described in Section 102(g).
   c. The total amount of NHTF assistance shall not exceed the maximum per-unit development subsidy amount established by the Department as stated in the NOFA.
   d. HHC loans shall be secured by the project's real property and improvements and subject only to liens, encumbrances and other matters of record approved by the Department, consistent with 25 CCR Section 8315. Projects with ground leases shall be subject to 25 CCR Section 8316.
   e. HHC assistance provided as post-construction permanent loans shall have an initial term of 55 years or longer to match the period of affordability restrictions under the tax credit program, commencing on the date of recordation of the HHC loan documents.

(2) Grants for project-based operating assistance in the form of a Capitalized Operating Subsidy Reserve (COSR).

The project's COSR will be for at least 15 years to pay for operating costs of an apartment or apartments receiving capital funding to provide Supportive housing to the Target Population.

(b) Maximum per-unit loan amounts for loans underwritten by the Department shall be published annually for each NOFA and determined as follows:

(1) Maximum per-unit loan amounts shall not exceed the total eligible costs required, when considered with other available financing and assistance, in order to:
a. Enable the funds to be used for the eligible uses;
b. Ensure that rents for Assisted Units comply with Program requirements; and
c. Operate in compliance with all other Program requirements.

(2) The capital portion of the loan amount is further limited to the sum of a base amount per Assisted Unit, plus the amount per Assisted Unit required to reduce rents from 30 percent of the 30 percent of AMI level to the actual maximum restricted rent for the Assisted Unit, with loan limits increasing based on the level of affordability provided.

(3) For loan limit calculations, the Department shall include the number of Assisted Units within a rental housing development and the number of bedrooms per Assisted Unit.

(4) For Assisted Units receiving rental assistance under renewable rental subsidy contracts, the loan amount will be based on the most restrictive level of income restriction that will apply following the closing of the program loan.

(5) Initial base amounts for the portion of the loan that does not include a COSR are set pursuant to the Department's Annual Action Plan.

(6) The COSR portion of the loan shall be determined pursuant to the requirements of Section 108.

(7) Beginning January 2020, the amounts in subparagraph (5), above, will be adjusted annually based upon increases in the Consumer Price Index. The maximum per-unit amounts for loans underwritten by the Department shall be updated annually and published in the NOFA.

(c) Recipients shall ensure that all Assisted Units meet all applicable federal and state property standards. Compliance with 24 CFR 93.301(a)(1) and (2) must be maintained for the duration of the affordability period of 55 years, except projects developed on Indian Reservation or Native American lands, which will be for at least 50 years.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 104. Loan Terms

(a) HHC loans shall have the following terms:

(1) They shall bear simple interest at the rate of 3 percent per annum on the unpaid principal balance, unless the Department reduces this rate pursuant to Health and Safety Code Section 50406.7. Interest shall accrue from the date funds are disbursed to, or on behalf of, the borrower.

(2) Pursuant to 24 CFR section 93.204(b)(1), HCD will charge fees to cover the cost of ongoing monitoring and physical inspection of NHTF rental projects during the state period of affordability and as determined in the NOFA.

(3) Except for the required monitoring fee payment, and if the borrower is not in default, the Department shall permit the deferral of accrued interest for the term of the loan.

(4) The Department may require a third-party tax professional to verify the necessity for reducing the interest rate below 3 percent, the cost of which shall be borne by the Sponsor.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 105. Occupancy and Income Requirements

(a) Household income shall be determined in accordance with the rules in 24 CFR 93.151. At the time of move-in, the household income shall not exceed the established Extremely Low Income (ELI) limits or families with incomes at or below the poverty line (whichever is greater) pursuant to 24 CFR 93.250(a). Income levels shall be expressed in 5 percent increments as a percentage of AMI. The income limits are posted on the Department's website. Assisted units will be restricted per the income limits set forth in the Project Regulatory Agreement.

(b) The Recipient shall maintain documentation of tenant-income eligibility and how they meet the requirements for the Target Population the following ways, as applicable:

(1) Documentation of enrollment in or eligibility for Medi-Cal benefits.

(2) Documentation of a person's status as Chronically homeless could be captured through any of the following:
   a. A client's entry and exits documented in a Homeless Management Information System;
   b. An outreach worker or Case Manager's written observations; or
   c. A client's self-report of episodes of homeless and disability status. Such reports must be done in accordance with procedures established through the local Coordinated Entry System or other procedures established by

the county for determining whether a person qualifies as Homeless and High-cost health user or Chronically homeless.

(3) Documentation of a person's status as a High-cost health user could be captured through any of the following:
   a. Discharge summaries; or
   b. An outreach worker's, case manager's or local County's health department written observations.

(c) Occupancy requirements shall apply for the full term of the regulatory period.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 106. Rent Limits

(a) Assisted Unit rent will be restricted in accordance with the NHTF rent and income limits in 24 CFR 93.302.

(1) ELI tenants. The rent plus utilities of an ELI tenant shall not exceed the greater of 30 percent of the federal poverty line or 30 percent of the income of a family whose annual income equals 30 percent of the median income for the area, as determined by HUD, with adjustments for the number of bedrooms in the unit. HUD will publish the NHTF rent limits on an annual basis. Rents will be further restricted in accordance with Rent and income limits submitted by the Sponsor in its application for the Program loan, approved by the Department, and set forth in the Regulatory Agreement.

(b) The income of each tenant must be determined initially in accordance with 24 CFR 93.151. In addition, in each year during the period of affordability (up to 55 years), the project owner must reexamine each tenant's annual income in accordance with one of the options in 24 CFR 93.151(c) selected by the Recipient and as identified in the tenant selection plan.

(c) Over-income tenants. Assisted Units continue to qualify as affordable housing despite a temporary noncompliance caused by increases in the incomes of existing tenants if actions satisfactory to HUD are being taken to ensure that all vacancies are filled in accordance with 24 CFR Part 93.302(g) until the noncompliance is corrected.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 107. Underwriting Standards

(a) In analyzing feasibility, the Department shall follow the underwriting requirements of its UMRs commencing with 25 CCR Section 8300 and/or federal NHTF regulations, including the following:

(1) 25 CCR Section 8303 (Site Control Requirements and Scattered Site Projects);

(2) 24 CFR 93.201(e) (Operating Cost Assistance and Operating Cost Assistance Reserves);

(3) 25 CCR Section 8309 (Replacement Reserves);

(4) 25 CCR Section 8310 (Underwriting Standards) and 24 CFR 93.300(b). The more strict requirements shall apply;

(5) 25 CCR Section 8311 (Limits on Development Costs);

(6) 25 CCR Section 8312 (Developer Fee);

(7) 25 CCR Section 8314 (Use of Operating Cash Flow), and 24 CFR Part 93. The stricter requirements shall apply; and

(8) 25 CCR Section 8315 (Subordination Policy).

(b) Where there is a difference between the provisions of the UMRs and these Guidelines, the provisions of these Guidelines shall prevail.

(c) Notwithstanding the above, residential stabilized vacancy rates for Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market data or other evidence.

(d) In addition to the operating reserve required by 25 CCR 8308, a Sponsor may establish a COSR for the Assisted Units meeting the requirements of Section 108.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 108. Capitalized Operating Subsidy Reserves

NHTF grant funds may be used to pay for Capitalized Operating Subsidy Reserves (COSR) with the following conditions:

(a) For projects, not more than 100 percent of the total per-unit amount for capital determined pursuant to Section 103 may be provided per unit for a COSR to address project operating deficits attributable to the Assisted Units.

(b) The operating reserves shall be sized to cover anticipated operating deficits attributable to the Assisted Units for a minimum of 15 years. The total amount of each project's operating reserves will be determined based upon the individual project underwriting performed by the Department pursuant to the requirements of these Guidelines.

(c) In determining how to size each project's COSR, the Department shall consider individual project factors such as: the maximum percentage of Assisted Units it will assist; the anticipated project vacancy rates; the anticipated percentage of Assisted

Units that will have other operating or rental subsidy and the term of that operating or rental subsidy contract, and anticipated tenant incomes.

(d) The following standard assumptions will be used for establishing the total amount of the project COSR. The Department may modify these assumptions as necessary to maintain project feasibility or extend the term of the COSR.

(1) All Assisted Units, other than the proportionate share of the manager's unit, shall be counted in calculating the amount of the COSR. An Assisted Unit receiving other rental assistance may receive assistance from the COSR.

(2) The stabilized residential vacancy rate for the Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market or other evidence.

(e) Notwithstanding the above, in order to sustain the availability of the operating reserves for a minimum of 15 years, distributions from the COSR shall be subject to: The Department may not disburse more than 5 percent of the total COSR to a project per year, except that in any given year where the operating deficit attributable to the Assisted Units exceeds this amount, the Department may, in its sole discretion, increase the disbursement to up to 7 percent of the total COSR, in accordance with the operating reserves limits and applicable review processes;

(f) Asset management and partnership management fees and deferred developer fees shall only be paid in accordance with the requirements of Section 107.

(g) In accordance to 24 CFR 93.201(e)(1), Operating Expenses that are eligible to be paid from the COSR include:

(1) Insurance

(2) Utilities

(3) Real property taxes

(4) Maintenance

(5) Scheduled payments to a reserve for replacement of major systems

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 109. Award Limits

(a) The maximum loan limit per Applicant is $20,000,000. The limit on the amount that can be used for the COSR will be one third of the total loan amount, in accordance with 24 CFR 93.200(a)(1).

(b) NHTF funding will be made available to all jurisdictions in California. Pursuant to the Department's Annual Plan, the Department will set-aside at least 20 percent of the funding for projects located in Rural Areas. In the event no projects target the 20 percent set-aside for projects located in Rural Areas, funds will be distributed according to the distribution methods of 24 CFR 91.320(d) and (k).

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 110. Application Process

(a) Contingent upon an annual federal NHTF allocation, the Department shall issue a competitive NOFA for NHTF funding that specifies, among other things, the amount of project funds available, any restrictions on uses of funds, general terms and conditions of funding applications, minimum requirements, timeframe for submittal of applications, application requirements, and rating metrics. Application requirements include, but are not limited to, the following:

(1) Identification of Applicants;

(2) Information on the proposed project;

(3) Adequate information to determine Applicant's eligibility;

(4) Adequate information to determine project's eligibility;

(5) Certification of compliance with federal and state requirements;

(6) Resolution by the governing board authorizing the application and execution of all documents;

(7) Adequate information to determine Applicant's experience;

(8) Site control;

(9) Compliance with the state's policy on Housing First;

(10) Project readiness to proceed;

(11) A Supportive Services plan, including staff-to-client ratio (1:20);

(12) Commitment of services funding; and

(13) Adequate information to determine the project's feasibility.

(b) Applications shall be on forms made available by the Department.

(c) Applications shall be evaluated for compliance with the minimum requirements set forth in Section 102 and will be rated and ranked in accordance with the criteria outlined in Section 111. Applicants that do not meet the minimum requirements will

be rejected and will not be rated. Applicants will be subject to the appeal process as detailed in the NOFA.

(d) If requesting a COSR, the Applicant must comply with the requirements in Section 108 of these Guidelines.

(e) The Department reserves the right to do the following:

(1) Score an application as submitted in the event information is missing from the application; and

(2) Request clarification of unclear or ambiguous statements made in an application, and other supporting documents, when doing so will not impact the competitive scoring of the application. No additional information may be introduced into the application documentation.

(f) Applications selected for funding shall be approved at amounts, terms, and conditions specified by these Guidelines and the NOFA.

(g) Each project must achieve the minimum scores in the Development Team Experience, Supportive Services plan, and Readiness to Proceed scoring categories, as follows:

(1) Development Team Experience: 18 points

(2) Supportive Services plan: 10 points

(3) Readiness to Proceed: 15 points

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 111. Application Selection Criteria

The criteria detailed below and summarized in the following table shall be used to rate applications. In the event of tied point scores, the following tiebreakers shall be used to determine which project is selected for funding, in the order listed:

(1) The Readiness to Proceed point score, pursuant to Section 111(f) of these Guidelines; and

(2) The Supportive Services plan point score, pursuant to Section 111(c) of these Guidelines

	Maximum Applicable Points
Development Team Experience	
Developer Experience	10
Applicant Ownership	5
Property Management	5

Lead Service Provider	15
Total Development Team Experience	**35**
Supportive Housing Units	25
Supportive Services plan	25
Utilization of Funds to Offset Requests	10
Leverage of Rent/Op Subsidies	15
Readiness to Proceed	30
Confirmation of Local Need	5
Location Efficiency and Access to Destinations	5
TOTAL APPLICABLE POINTS	**150**

(a) Development Team Experience (35 points maximum). The Applicant must achieve a minimum of 18 points from this section to receive an award.

(1) Developer Experience (10 points maximum)
   a. Applications will be scored based on the number of affordable rental housing developments completed by the project developer over the past five years, including Supportive housing projects completed in the last three years serving persons similar to the Target Population. Applicant should address whether these projects were completed timely and within budget. Delays and cost overruns should be explained.
   b. Two points will be awarded for each completed development that was timely and within budget, up to a maximum of ten points.

(2) Applicant Ownership and Operations Experience (5 points maximum)
   a. Applications will be scored based on the experience of the Applicant in owning or operating (under a long-term master lease or similar arrangement) supportive and/or affordable rental housing developments.
   b. The Applicant's experience includes the experience of its affiliated entities or principals (including management-level staff), but not the experience of board members. If there are multiple entities that comprise the ownership entity of the proposed project, the score will be based on the experience of the entity with a controlling interest in the ownership entity and a substantial and continued role in the project's operations, as evidenced in the ownership entity's legal documents.
   c. One-half point will be awarded for each affordable housing project, and one point will be awarded for each Supportive housing project, up to a maximum of five points.

(3) Property Manager Experience (5 points maximum)
   a. Applications will be scored based on the number of affordable and Supportive housing developments managed by the designated property management agent at the time of application. One-half point will be awarded for each affordable housing development, and one point will be awarded for each Supportive housing development, up to a maximum of five points.
   b. Points will be awarded for Supportive housing developments that have been in operation for at least two years with units restricted to people

experiencing homelessness.

(4) Lead Service Provider Experience (15 points maximum)

a. Points will be awarded for experience in the last five years providing comprehensive case management and tenancy support to people experiencing homelessness, and for demonstrated expertise working with the Target Population.

b. Experience must be documented through contracts with public agencies, housing owners, or foundations for services in housing projects with at least ten units subject to agreements with public agencies restricting rent or occupancy to Homeless persons or households, or in publicly funded tenant-based housing assistance programs serving at least ten members of the Target Population.

Points will be awarded for the following:

1. Years of experience in permanent Supportive housing (3 points maximum).
   i. One to two years (1 point)
   ii. Three years to four years (2 points)
   iii. Five years or more (3 points)
2. Number of projects or contracts in permanent Supportive housing (3 points maximum).
   i. One to two projects (1 point)
   ii. Three to four projects (2 points)
   iii. Five or more projects (3 points)
3. Years of experience serving the Target Population (3 points maximum).
   i. One to two years (1 point)
   ii. Three years to four years (2 points)
   iii. Five years or more (3 points)
4. Experience providing comprehensive case management, where members of the Target Population were at least 20 percent of the Lead Service Provider's clients during the years for which points are sought in any of the following (two points for either of the following):
   i. Permanent Supportive housing restricted to members of the Target Population; or
   ii. Permanent Supportive housing not restricted to members of the Target Population, with documented experience providing Homeless services with documented retention rates of at least 85 percent after 12 months.

   To receive points under subsection i. or ii. above, the Lead Service Provider must have current staff expertise and organizational experience:
   i. Connecting members of the Target Population and/or Homeless individuals with community-based health care services, including linkage to primary care services and behavioral health care; and
   ii. Staff expertise and experience must be documented through resumes, job descriptions, contracts, staff training descriptions, and letters from Continuums of Care or other supportive services organizations.

5. Experience of a partner agency if the following conditions are satisfied (2 points):
    i. An executed agreement between the two agencies must be submitted with the application for HHC assistance; and
    ii. The agreement must have a term of at least five years and detail the cultural competency services to be provided by the partner agency. These services must include:
        a. Technical assistance with program development;
        b. Training and mentoring of Lead Service Provider leadership and staff for the proposed project;
        c. Assistance with hiring project staff;
        d. Assistance with developing community linkages;
        e. Other technical assistance as needed; and
        f. An agreement to provide services to members of the Target Population residing in the project that are referred by the Lead Service Provider.

6. Documented success in meeting or exceeding specified outcome measures for housing stability under a government contract for at least two years as a Lead Service Provider in Permanent Supportive housing serving persons experiencing homelessness. (2 points)

(b) Supportive Housing (25 points maximum).

(1) Applications will be scored based on the percentage of total project units restricted as Supportive housing in accordance with the table in subsection (2) below.

(2) To receive any points in this category, a minimum of 5 percent of total project units must be restricted as Supportive housing.

The scoring table is as follows:

Percentage of Total Project Units Restricted as Supportive Housing	Points
5%	**5**
10%	**9**
15%	**13**
20%	**17**
25%	**21**
30% or more	**25**

(c) Supportive Services Plan (25 points maximum). The Applicant must achieve a minimum of 10 points from this section to receive an award.

(1) Applications for projects will be scored based on the following:
a. Quality and Quantity of Services (7 points maximum)
    1. The services provided are of appropriate quality and quantity for the Target Population. (2 points)

2. Staff experience, credentials, and job duties include appropriate skills in cultural competency. (2 points)
3. The service delivery model, tailored to Homeless people impacted with one or more chronic health or behavioral health conditions, that includes, but is not limited to, the following: (3 points)
    i. Use of a critical time intervention or assertive community treatment model
    ii. Cognitive behavioral therapy
    iii. Trauma-informed care
    iv. Motivational interviewing and other tools to encourage engagement in services
    v. Other practices recognized as evidenced-based by the Substance Abuse and Mental Health Services Administration (SAMHSA), DHCS, HUD, or other federal or state public agencies

b. The accessibility of services, whether they are on-site or in close proximity to the project, including the hours they are available, and the frequency, travel time and cost of transportation required to access them, including both public transportation and private transportation services (e.g. van owned by the provider), and how the service provider will assist in the expense of public transportation (e.g., provide tokens, negotiate discounts, provide their own shuttle service, etc.). (2 points)
c. Adherence to Section 113, Housing First principles in the provision of services, including provision of flexible services that facilitate Permanent housing access and housing stability. (2 points)
d. The degree to which the physical building space supports social interaction, the provision of services and ensures the safety of all residents, especially those more vulnerable, such as persons with a history of trauma, children, elderly, etc. (1 point)
e. The levels of linkages with local systems for ending homelessness and community-based health care resources for members of the Target Population, including: (5 points)
    1. Participation, verified by the local Continuum of Care, in a local CES that is fully established.
    2. The degree of coordination with primary care providers, behavioral health providers, and health care facilities.

(2) Resident Involvement (3 points maximum)
Points will be awarded based on the quality of:
a. Strategies to engage residents to encourage participation in services (1 point);
b. Strategies to engage residents in services planning and operations (1 point); and
c. Tenant satisfaction surveys to inform and improve services, building operations, and property management. (1 point)

(3) The adequacy of the services budget and the reliability over time of services funding (5 points maximum)
Points will be awarded based on:

a. The adequacy and accuracy of budgeted income sources and uses and the consistency of these amounts with other sections of the services plan. (1 point)
b. The completeness, accuracy, specificity and clarity of the budget document. (1 point)
c. The extent to which the major services funding sources have been accessed by the designated service providers or Applicant in the past. (1 point)
d. The track record of the Applicant and providers in filling gaps in services funding left by the loss of major funding sources. (1 point)
e. The percentage of the total services budget that is committed at the time of application. (1 point)

(d) Utilization of Funds to Offset Requests (10 points maximum)

(1) Applications will be scored based on the ratio of permanent affordable development funding attributable to Assisted Units from sources other than NHTF to the requested NHTF loan amount. Deferred developer fees and funds deposited in a reserve to defray scheduled operating deficits will not be counted in this computation. Land donations will be counted where the value is established by a current appraisal.

(2) For projects utilizing 9 percent competitive low-income housing tax credits, 0.375 points will be awarded for each full 5 percentage point increment above 50 percent. For example, an application proposing other funds equal to 100 percent of the NHTF funds will receive 3.75 points. An application where other funds equal 250 percent of NHTF funds will receive 10 points.

(3) For other projects not utilizing 9 percent competitive low-income housing tax credits, 0.75 points will be awarded for each 5 percentage point increment above 50 percent. For example, an application proposing other funds equal to NHTF funds will receive 7.5 points, and an application where other funds equal 150 percent of NHTF funds will receive 10 points.

(e) Leverage of Rental or Operating Subsidies (15 points maximum)

(1) Applications will be scored based on the percentage of Assisted Units that either:
a. Have committed project-based rental or operating subsidies substantially similar in terms to project-based housing choice vouchers to indicate a high likelihood of receiving similar funding for the proposed project; or
b. Are restricted to rents not exceeding 30 percent of household income, with project feasibility determined based on the assumption that rents will be affordable to tenants of existing projects targeting Homeless populations, as specified in the HHC application.

(2) Project-based housing choice vouchers will be deemed committed if they have been allocated to the project and approved by HUD, or if the Department approves other evidence that they will reliably be available (such as a letter from the housing authority committing to project-based housing choice

vouchers to the project).

(3) One point will be awarded for each 5 percentage point increment, up to a maximum of 15 points.

(f) Readiness to Proceed (30 points maximum). The Applicant must achieve a minimum of 15 points from this section to receive an award.

The Supportive Services must be fully implemented and available for use by the tenant at the time of occupancy. Points will be awarded as shown below to projects for each of the following circumstances as documented in the application. Any application demonstrating that a particular category is not applicable to project readiness for the subject project shall be awarded points in that category.

(1) Obtained enforceable commitments for all construction financing, not including tax-exempt bonds, low-income housing tax credits, and funding to be provided by another Department program. Other Department funds must be awarded prior to the application deadline. (5 points)

(2) Completion of the California Environmental Quality Act, if necessary and not entitled to a streamlined review under AB 2162, and
   a. Phase I Environmental Site Assessment (ESA-ASTM) for projects with NHTF only, or
   b. If any other federal funding sources are utilized, the project must complete a Phase I Environmental Site Assessment with the National Environmental Policy Act. (5 points)

(3) Obtained all necessary and discretionary public land use approvals, except building permits and other ministerial approvals, or documented to be an eligible project under AB 2162. (5 points)

(4) 5 points will be awarded if either:
   a. The Applicant has fee title ownership to the site or a long-term leasehold securing the site meeting the criteria for HHC site control; or
   b. The Applicant can demonstrate that the working drawings are at least 50 percent complete, as certified by the project architect;

(5) Obtained local design review approval to the extent such approval is required. (5 points)

(6) Obtained commitments for all deferred-payment financing, grants and subsidies, in accordance with TCAC requirements and with the same exceptions as allowed by TCAC. Deferred payment financing, grant funds, and subsidies from other Department programs must be awarded prior to application deadline. (5 points)

(g) Local Need (5 points maximum)

More than 400 individuals are Homeless in the Applicant's geographic jurisdiction using the latest PIT count and as stated in the NOFA.

(h) Location Efficiency and Access to Destinations (5 points maximum)

Location Efficiency and Access to Destinations refers to reasonable access and proximity to amenities, services, and public transportation that allows members of the Target Population to have choices in accessing resources for independent living.

Points may be awarded cumulatively across the categories below up to a total of five points. Applicants must provide a map demonstrating proximity for items (1) and (2) to be eligible for the respective points.

(1) Projects located where there is a rapid transit station, light rail station, commuter rail station, ferry terminal, bus station, or public bus stop within one-half mile (one mile for Rural Areas) from the site, with service at least every 30 minutes (or at least two departures during each peak period for a commuter rail station or ferry terminal) during the hours of 7 a.m. - 9 a.m. and 4 p.m. – 6 p.m., Monday through Friday. (1 point)

(2) Projects that provide a map highlighting the location of the existing and operational services within one-half mile of the project area (two miles for Rural Areas), as follows:
   a. (1 point) Grocery store which meets the CalFresh Program requirements;
   b. (1 point) Medi-Cal clinic that accepts Medi-Cal payments;
   c. (1 point) Public elementary, middle or high school; and
   d. (1 point) Licensed child care provider.

(i) Applicants will be subject to the appeal process as detailed in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 112. Supportive Services

(a) Each application must include a project-specific Supportive Services plan. This plan is to be developed by the Lead Service Provider and the property manager and shall include information listed in (c) and (d) of this section. Recipients must utilize a Lead Service Provider.

(b) The property management staff and service providers must make participation in Supportive Services by HHC tenants voluntary. Access to or continued occupancy in housing cannot be conditioned on participation in services or on sobriety. The Supportive Services plan must describe the services to be made available to HHC tenants in a manner that is voluntary, flexible and individualized, so HHC tenants may continue to engage with supportive services providers, even as the intensity of services needed may change. Adaptability in the level of services should support tenant engagement and housing retention.

(c) Using evidence-based models, the following Supportive Services shall be made

available to HHC tenants based on tenant need. Except as otherwise noted below, the following required services shall be provided onsite at the project or offsite at another location easily accessible to tenants, with the majority of case management services offered on-site:

(1) Assistance accessing and linking tenants to Medi-Cal enrollment and enrollment in other benefits the tenant may be eligible for;

(2) Case management;

(3) Peer support activities;

(4) Support in linking to behavioral health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups;

(5) Support in linking to primary care services, including access to routine and preventive health and dental care, medication management, and wellness services;

(6) Benefits counseling and advocacy, including assistance in accessing Supplementary Security Income/State Supplemental Payment (SSI/SSP);

(7) Basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, working with a landlord, getting along with neighbors, and money management); and

(8) Services for persons with co-occurring mental and physical disabilities or co-occurring mental and substance use disorders not listed above.

The following Supportive Services are not required to be made available but are encouraged to be part of a project's Supportive Services plan.

(1) Recreational and social activities;

(2) Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process;

(3) Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work; and

(4) Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

(d) The following additional information shall be provided in the Supportive Services plan:

(1) Description of the Target Population to be served and identification of any

additional subpopulation target or occupancy preference for the HHC project that the Applicant wishes to undertake beyond what is permitted under the Target Population requirements. Any additional subpopulation targeting or occupancy preference for the HHC project must be approved by the Department prior to construction loan closing and must be consistent with federal and state fair housing requirements;

(2) Description of tenant outreach, engagement, and retention strategies to be used;

(3) Description of each service to be offered, how frequently each service will be offered or provided depending on the nature of the service, who is anticipated to be providing the services, the location, and general hours of availability of the services;

(4) For services provided off-site, the plan must describe what public or private transportation options will be available to HHC tenants in order to provide them reasonable access to these services. Reasonable access is access that does not require walking more than one-half mile;

(5) Description of how the Supportive Services are culturally and linguistically competent for persons of different races, ethnicities, sexual orientations, gender identities, and gender expressions. This includes explaining how services will be provided to HHC tenants who do not speak English or have other communication barriers, including sensory disabilities, and how communication among the services providers, the property manager and these tenants will be facilitated;

(6) Estimated itemized budget and sources of funding for services;

(7) Description of how the supportive services staff and property management staff will work together to prevent evictions, to adopt and ensure compliance with harm reduction principles, and to facilitate the implementation of reasonable accommodation policies from rent-up to ongoing operations of the project;

(8) General service provider and property manager communication protocols;

(9) Description of how the physical design of the project fosters tenant engagement, onsite supportive services provision, safety and security, and sustainability of furnishings, equipment, and fixtures; and

(10) Other information needed by the Department to evaluate the Supportive Services to be offered consistent with the Program.

(e) Copies of draft written agreements or memoranda of understanding (MOUs) that identify the roles and responsibilities of the Recipient, the project owner, other service providers, and the property manager must be provided. The draft written agreements or MOUs must be materially consistent with the information set forth in the Supportive Services plan.

The Department may request that any necessary updates to the Supportive Services plan or related documents, including fully executed written agreements between the county, service providers, the project owner, and the property manager, be provided prior to the beginning of the initial rent-up period or prior to permanent loan closing.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 113. Housing First

(a) Projects shall employ Housing First practices that are documented in the application, property management plan and Supportive Services plan. Adherence to the Housing First core components pursuant to Welfare and Institutions Code Section 8255(b).

(b) For all HHC funded projects, Housing First property management and services delivery practices shall be followed. Housing First practices include the following:

1. Tenant selection practices shall be done in conjunction with the local Coordinated Entry System and promote the acceptance of Applicants regardless to their sobriety or use of substances, completion of treatment, or agreement to participate in services;

2. Applicants are not rejected based on poor credit or financial history, poor or lack of rental history, or criminal convictions unrelated to tenancy, or behaviors that indicate a lack of “housing readiness”;

3. Applicants are assisted in making application for tenancy and reasonable accommodation requests;

4. Supportive Services are flexible and voluntary and focus on housing stability, engagement, and problem solving over therapeutic goals; and

5. The lack of policies or practices regimenting daily activities or limiting privacy, visitors, or the individual’s ability to engage freely in community activities or to manage their own activities of daily living.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 114. Tenant Selection

Tenants must meet income requirements in Section 105 and Target Population requirements in Section 102.

Recipients shall accept referrals through use of a CES or other similar system in accordance with the provisions of 25 CCR Section 8305, and in compliance with Housing First requirements consistent with the core components set forth in Welfare and Institutions Code Division 8 Chapter 6.5 Section 8255 subsection (b), and basic tenant protections established under federal, state, and local law.

(a) Reasonable selection criteria, as referred to in 25 CCR Section 8305(a)(1), shall include priority status under a local CES developed pursuant to 24 CFR 578.7(a)(8).

(b) If the CES existing in the county cannot refer persons in the Target Population, the alternative system used must prioritize those with the greatest needs among those for referral to available Assisted Units.

(c) Recipients shall accept tenants regardless of sobriety, participation in services or treatment, history of incarceration, credit, or history of eviction in accordance with practices permitted pursuant to WIC Section 8255 or other federal or state project funding sources.

(d) Projects must also provide a preference for accessible units to persons with disabilities requiring the features of the accessible units in accordance with Section 10337(b)(2) of the TCAC regulations.

The requirements of 25 CCR Section 8305 (a)(4)(A) and 25 CCR Section 8305 (a)(4)(D) shall be implemented as approved by the Department in a manner that is consistent with the requirements of the CES.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 115. Rental Agreements and Grievance Procedures

Rental or occupancy agreements and grievance procedures for Assisted Units shall comply with 25 CCR Section 8307 and 24 CFR 93.303. Tenants shall not be required to maintain sobriety, be tested for substances, or participate in services or treatment.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 116. Vulnerable Populations Best Practices

The following best practices should be incorporated in the construction of projects that receive funding from HHC, to the extent possible. These best practices work

to further the safety and physical and mental well-being of residents within a project.

(a) General best practices for all developments:

(1) Safety Features:
   a. Site selection and development of the project should consider the safety concerns of the prospective tenants.
   b. Building entrance and exit points should only allow admittance to residents or guests that residents admit.
   c. Common areas within the project should be oriented so as to have:
      1. Two ways to enter or exit the area;

2. Visibility to the area from outside of it, i.e. windows in walls or doors; and
3. A centralized location, to the extent possible.

d. Safety lighting that reduces or eliminates blind or dark spaces where people can hide.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(b) For those populations that have a history of sexual trauma and/or domestic violence:

(1) Safety features incorporate all the general best practices and include the following:

a. For projects that will also be serving women with a history of domestic violence or sexual trauma:

1. Designate at least 25 percent of the Assisted Units will be for women with a history of domestic violence or sexual trauma and/or women with children, thereby ensuring women are not a small minority of the tenancy.
2. Design projects to provide separate and secure floors, wings, or buildings for women with a history of domestic violence or sexual trauma and/or women with children. These separate and secure areas should restrict access to only the residents in the secured area.

b. Security cameras:

1. At entrances, exits and common areas (including hallways, elevators, and stair wells);
2. Written policy on the use of the cameras to specify who has access to see the videos, who monitors the surveillance, and under what conditions footage would be released to the authorities; and
3. Camera recordings should be maintained for at least 30 days.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

The project should have 24-hour security if it serves persons impacted by domestic violence, transition age youth and other vulnerable populations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 117. Reporting Requirements

Recipient must collect and report data, as described in Section 53593, to the Department at annual and midyear intervals. Reporting of the following is required:

(a) Not later than 90 days after the end of each project's fiscal year, the Recipient shall submit an independent audit of the development prepared by a certified public accountant and in accordance with the Department's current audit requirements and all other applicable requirements, as stated by law or included in the NOFA.

(b) Recipients shall report on the sources of tenant referrals for the project and submit both client data and performance outcome data to the Department. Tenant data may include, but is not limited to, demographic information. Performance outcome data shall include, but is not limited to, information on housing stability, tenant satisfaction as measured in a survey, and changes in income and benefits received.

(c) Recipients shall report the number of participants living in the Supportive housing project after 12 months, 24 months, and 36 months, as relevant.

(d) Recipients shall report the number of participants and the type of interventions offered through the grant funds.

(e) Recipients shall report on the number of participants who exited the project each year and where they exited to, including other Permanent housing, homelessness, or death.

(f) To the extent available and feasible, Recipients shall provide data on the impact of the Program on participants' use of corrections systems and law enforcement resources.

(g) If Recipient is a local government, must comply with 2 CFR Part 512, as outlined in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53593.

Section 118. Operating Budgets

The Recipient shall submit proposed operating budgets to the Department prior to occupancy, and annually thereafter. These budgets shall be subject to Department approval and comply with the requirements in 25 CCR Section 7326.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 119. Federal and State Overlays

(a) Federal Overlays. Activities funded with HHC funds are required to comply with 24 CFR Part 93.350 and 24 CFR Part 93.301. Compliance with these requirements include, but are not limited to, environmental provisions, federal Davis-Bacon Wage requirements and state prevailing wage laws, relocation, Equal Opportunity and Fair Housing, Fair Housing Amendments Act, Affirmative Marketing, Section 504 of the Rehabilitation Act and its implementing regulations, and the Americans with Disabilities Act and its implementing regulations, Section 3 (employment of low-income persons), Violence Against Women Act, and Single Audit report 2 CFR Part 200.512. Failure to comply with federal overlays could result in significant project cost increases, and rejection of the HHC application.

(b) State Overlays. Article XXXIV of the California Constitution requires local voter approval before any state public body can develop, construct, or acquire a low-rent housing project in any manner. However, the Public Housing Election Implementation Law (Health & Safety. Code, §§ 37000 - 37002) provides clarification as to when Article XXXIV is applicable.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 120. Legal Documents

After a Recipient is sent a letter providing notice of award pursuant to a NOFA, and prior to actual disbursement of funds pursuant to that award, the Department and Recipient shall enter into a state “Standard Agreement” that shall constitute a conditional commitment of said funds. The Standard Agreement shall require the Recipient to comply with the requirements and provisions of these Guidelines, and generally applicable state contracting rules and requirements. The Standard Agreement shall encumber state moneys in an amount no more than as established in the NOFA and said amount shall be consistent with the application and corresponding award letter. The Standard Agreement shall contain the terms necessary to ensure the Recipient complies with all HHC-NHTF requirements, including, but not limited to, the following:

(a) Requirements for the execution of a promissory note, operating reserve agreement, or other project-specific contracts as may be applicable;

(b) Requirements set forth in the NOFA;

(c) Requirements, where appropriate, for the execution and recordation of covenants, regulatory agreements, or other instruments restricting the use and occupancy of and appurtenant to the project and the property thereunder (for the purposes of these Guidelines, all such documents are collectively herein referred to as the HHC regulatory agreement;

(d) Requirements for the execution of a Deed of Trust or other security instrument securing the debt owed by the borrower to the Department for the amount of the award. The Deed of Trust must be recorded against the fee estate underlying the property; leasehold security will not be accepted unless such security strictly meets

the requirements set forth in 25 CCR Section 8316;

(e) The Recipient's responsibilities for timing and completion of the project, as well as all reporting requirements;

(f) Remedies available to the Department in the event of a violation, breach or default of the Standard Agreement; and

(f) All other provisions necessary to ensure compliance with the requirements of HHC and applicable state and federal law.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2), 53593 and 53595.

Section 121. Defaults and Loan and/or Grant Cancellations

(a) In the event of a breach or violation by the Recipient of any of the provisions of HHC-NHTF requirements, the regulatory agreement, the promissory note, or the deed of trust, or any other agreement pertaining to the project, the Department may give written notice to the Recipient to cure the breach or violation within a period of not less than 15 days. If the breach or violation is not cured to the satisfaction of the Department within the specified time, the Department, at its option, may declare a default under the relevant document(s) and may seek legal remedies for the default, including but not limited to the following:

(1) The Department may accelerate all amounts, including outstanding principal and interest, due under the loan and demand immediate repayment thereof. Upon a failure to repay such accelerated amounts in full, the Department may proceed with a foreclosure in accordance with the provisions of the Deed of Trust and state law regarding foreclosures.

(2) The Department may seek, in a court of competent jurisdiction, an order for specific performance of the defaulted obligation or the appointment of a receiver to operate the project in accordance with HHC-NHTF requirements.

(3) The Department may seek such other remedies as may be available under the relevant agreement or any law as it relates to both the loan and the COSR grant.

(4) Suspension from future Department funding awards.

(5) The Department may seek other remedies set forth in the relevant agreement or any other applicable legal or equitable remedies law.

(b) If the breach or violation involves charging tenants rent or other charges in excess of those permitted under the regulatory agreement, the Department may demand the return of such excess rents or other charges to the respective households. In any action to enforce the provisions of the regulatory agreement, the Department may seek, as an additional remedy, the repayment of such overcharges.

(c) The Department may cancel loan commitments or COSR grants under any of the following conditions:

(1) The objectives and requirements of HHC cannot be met;

(2) Implementation of the project cannot proceed in a timely fashion in accordance with the approved plans and schedules;

(3) Special conditions have not been fulfilled within required time periods;

(4) There has been a material change, not approved by the Department, in the principals or management of the Recipient or project; or

(5) If the Recipient fails to apply for Tax Credit funding, which they relied on for project feasibility in their application, within 18 months of the HHC award date.

The Department, in writing and upon demonstration by the Recipient of good cause, may extend the date for compliance with any of the conditions in this subsection, as long as these extensions are within the established/agreed upon deadlines established in the NOFA.

(d) Upon receipt of a notice from the Department of intent to cancel the loan or request to repay the grant, the Recipient shall have the right to appeal to the Director.

(e) The Department may use any funds available to it to cure or avoid a Recipient's default on the terms of any loan or other obligation that jeopardizes the fiscal integrity of a project or the Department's security in the project. Such defaults may include defaults or impending defaults in payments on mortgages, failures to pay taxes, or failures to maintain insurance or required reserves. The payment or advance of funds by the Department pursuant to this subsection shall be solely within the discretion of the Department and no Recipient shall be entitled to or have any right to payment of these funds. All funds advanced pursuant to this Subsection shall be part of the HHC loan or COSR grant and, upon demand, due and payable to the Department. Where it becomes necessary to use state funds to assist a project to avoid threatened defaults or foreclosures, the Department shall take those actions necessary, including, but not limited to, foreclosure or forced sale of the project property, to prevent further, similar occurrences and ensure compliance with the terms of the applicable agreements.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2), 53593 and 53595.

Article II. Building Homes and Jobs Trust Fund Allocation

Section 200. Purpose and Scope

(a) In September of 2017, AB 74 was signed into law. This legislation authorizes the California Department of Housing and Community Development (Department) to develop the Housing for a Healthy California (HHC) program to create Supportive housing for individuals who are recipients of or eligible for health care provided through the California Department of Health Care Services (DHCS) Medi-Cal program. The goal of HHC is to reduce the financial burden on local and state resources due to the overutilization of emergency rooms or incarceration as the first point of health care provision for people who are Chronically homeless or Homeless and a High-cost health user. The Department shall coordinate with the DHCS, consistent with state and federal privacy law, to match Program participant data to Medi-Cal data to identify outcomes among participants, as well as changes in health care costs and utilization associated with housing and services provided under HHC.

(b) AB 74 allows the Department to utilize revenues appropriated to the Department from other revenue sources for HHC purposes. As directed in the 2018-2019 state Budget Act, the Department will utilize a portion of moneys collected in calendar year 2018 and deposited into the Building Homes and Jobs Trust Fund for the HHC program. The Department will allocate these funds competitively to counties for acquisition, new construction or reconstruction and rehabilitation, administrative costs, capitalized operating subsidy reserves (COSR), and rental subsidies for existing Supportive housing to assist HHC's Target Population. The Department has elected to incentivize utilizing locally committed funding in an amount at least equivalent to the requested HHC funding amount. Note, funds applied pursuant to Health and Safety Code Section 53594(a)(1) acquisition funding, new construction, and rehabilitation shall comply with Federal Housing Trust Fund regulations.

(c) In addition to applicable state and federal laws and regulations, these guidelines (hereinafter "Guidelines") implement, interpret, and make specific the HHC program authorized by Part 14.2 (commencing with Section 53590) of Division 31 of the Health and Safety Code and for Fiscal Year 2018 Chapter 2.5 (commencing with Section 50470) of Part 2 of Division 31 of the Health and Safety Code.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(1), 53594 and 50472.

Section 201. Definitions

All terms not defined below shall, unless their context suggests otherwise, be interpreted in accordance with the meaning of terms described in Part 14.2 of Division 31 of the Health and Safety Code (commencing with Section 53590).

(a) “Applicant” means a County, as defined below.

(b) “Area Median Income” or “AMI” means the most recent applicable County median family income published by HUD.

(c) “Assisted Unit” means a housing unit that is subject to the program’s rent and/or occupancy restrictions as a result of the financial assistance provided under the program.

(d) “Case Manager” means a social worker or other qualified individual who works with a tenant to offer individualized service planning that is flexible and creative to help the tenant gain housing stability. It includes working in collaboration with the tenant to plan, assess, coordinate, and reassess the tenant’s needs, as well as referrals and advocacy and connection to community support to meet tenants’ supportive services needs. Services include, but are not limited to: tenancy support services, coordination of medical and behavioral health, substance use disorder treatment, employment services, life skills training, peer support, and crisis management interventions. Resident service coordinators are not Case Managers.

(e) “Chronically homeless” has the same meaning as in Part 91.5 and 578.3 of Title 24 of the Code of Federal Regulations, except that people who were Chronically homeless before entering an institution would continue to be defined as Chronically homeless before discharge, regardless of length of stay, as those parts read on January 1, 2018.

(f) “Continuum of Care” is defined in 24 CFR Section 578.3.

(g) “Coordinated Entry System” or “CES” means a centralized or coordinated process developed pursuant to 24 CFR Section 578.7(a)(8), designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

(h) “County” means a county, city and county, or a city collaborating with a county to secure services funding.

(i) “DHCS” means the state Department of Health Care Services.

(j) “Department” means the Department of Housing and Community Development.

(k) “Development Sponsor” or “Sponsor”, as defined in Section 50675.2 of the Health and Safety Code and subdivision (c) of Section 50669 of the Health and Safety Code,

means any individual, joint venture, partnership, limited partnership, trust, corporation, cooperative, local public entity, duly constituted governing body of an Indian Reservation or Rancheria, or other legal entity, or any combination thereof, certified by the Department as qualified to own, manage, and rehabilitate a rental housing development. A Development Sponsor may be organized for profit, limited profit or be nonprofit, and includes a limited partnership in which the Development Sponsor, or an affiliate of the Development Sponsor, is a general partner.

(l) “Distributions” has the same meaning as under 25 CCR Section 8301(h).

(m)“Fair Market Rent” or “FMR” means the rent, including the cost of utilities, as established by HUD pursuant to Parts 888 and 982 of Title 24 of the Code of Federal Regulations, as those parts read on January 1, 2018, for units, by number of bedrooms, that must be paid in the market area to rent privately owned, existing, decent, safe, and sanitary rental housing of non-luxury nature with suitable amenities.

(n) "Fiscal Integrity" means, for any project for any given period of time during the term specified in the program’s regulatory agreement, that the total Operating Income for such project for such period of time, plus funds released pursuant to the Program documents from the project’s operating reserve account(s) during such period of time is sufficient to: (1) pay all current Operating Expenses for such project for such period of time; (2) pay all current mandatory debt service (excluding deferred interest) coming due with respect to such project for such period of time; (3) fully fund all reserve accounts established pursuant to the Program documents for such project for such period of time; and (4) pay other costs permitted by the Program documents for such project for such period of time. The ability to pay any or all the permitted annual distributions for a project shall not be considered in determining the Fiscal Integrity of a project.

(o) “Grantee” means an eligible Applicant that has been awarded funds under the program.

(p) “HHC” means the Housing for a Healthy California Program administered by the Department.

(q) “Health Homes Program” means the Health Homes Program, administered by the Department of Health Care Services, established pursuant to Article 3.9 (commencing with Section 14127) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(r) “High-cost health users” means people who have had either at least three emergency department visits or one hospital inpatient stay over the last year.

(s) “Homeless” has the same meaning as in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018.

(t) “Housing First” has the same meaning as in Welfare and Institutions Code Section 8255.

(u) “Lead Service Provider” or “LSP” means the organization that has the overall responsibility for the provision of Supportive Services and implementation of the Supportive Services plan. The LSP may directly provide comprehensive case management services or contract with other agencies that provide services.

(v) “Long-term rental assistance” means a rental subsidy provided to a housing provider, including a developer leasing affordable housing, to assist a tenant to pay the difference between 30 percent of the tenant’s income and Fair Market Rent or reasonable market rent as determined by the Department.

(w) “NOFA” means a Notice of Funding Availability.

(x) “Operating Expenses” has the same meaning as in 25 CCR Section 8301.

(y) “Operating Income” has the same meaning as in 25 CCR Section 8301.

(z) “Operating Cost Assistance Reserves” has the same meaning as in 25 CCR Section 8308.

(aa) “Permanent housing” means a housing unit where the landlord does not limit the length of stay in the housing unit, the landlord does not restrict the movements of the tenant, and the tenant has a lease and is subject to the rights and responsibilities of tenancy, pursuant to Chapter 2 (commencing with Section 1940) of Title 5 of Part 4 of Division 3 of the Civil Code.

(bb) “Point in Time Count” or “PIT” refers to an annual count of sheltered and unsheltered homeless persons on a single night in January.

(cc) “Program” means the Housing for a Healthy California Program created by this part.

(dd) “Supportive housing” means housing with no limit on length of stay, that is occupied by the Target Population, and that is linked to onsite or offsite services that assist the Supportive housing resident in retaining the housing, improving his/her health status, and maximizes his/her ability to live, and when possible, work in the community.

(ee) “Supportive Services” means social, health, educational, income support and employment services and, benefits; coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits.

(ff) “Target Population” means a person who is Chronically homeless or is Homeless and a High-cost health user upon initial eligibility, is a Medi-Cal beneficiary, is eligible for Supplemental Security Income, is eligible to receive services under a program providing services promoting housing stability, and is likely to improve his or her health conditions with Supportive housing.

(gg) “UMR” means the Uniform Multifamily Regulations commencing with 25 CCR Section 8300.

(hh) “Whole Person Care” Pilot or “WPC” has the meaning as described in the Medi-Cal 2020 Waiver Special Terms and Conditions (STCs), Sections 110-126, as approved by the federal Centers for Medicare and Medicaid Services on December 30, 2015.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53590 and 53595.

Section 202. Minimum Requirements

The Applicant shall comply with the requirements of HHC and all applicable federal and state laws.

(a) The Applicant shall meet all the following minimum requirements:

(1) Has identified a source of funding for providing intensive services promoting housing stability. Funding for these services may include, but is not limited to, one of more of the following:
   a. County general funds.
   b. WPC pilot program funds, to the extent those funds are available, or the WPC program has been renewed
   c. The Health Homes Program
   d. MHSA program
   e. Managed Care Organization
   f. Other County-controlled funding to provide these services to eligible participants

(2) Has developed a process for administering grant funds implementing affordable and Supportive housing projects. The agency the Applicant is partnering with, or the applying housing agency, must have either administered rental assistance or funded an affordable or Supportive housing project within the past three years.

(3) Agrees to collect and report data, as described in Section 219, to the Department.

(4) Must be compliant with both the housing element and their annual progress report submittals.

(b) The Applicant shall submit an application that meets the following requirements:

(1) The request for funding shall promote housing for persons who meet all the following requirements:
   a. Is Chronically homeless, or is homeless and a high-cost health user upon initial eligibility
   b. Is a Medi-Cal beneficiary
   c. Is eligible for Supplemental Security Income
   d. Is eligible to receive services under a program providing services promoting housing stability, including, but not limited to, the following:
      1. The WPC pilot program, to the extent the WPC program is available or has been renewed
      2. The Health Homes Program

3. A locally controlled service program funding or providing services in Supportive housing

e. Is likely to improve his or her health conditions with Supportive housing

(2) The use of funds proposed by the Applicant shall be clearly connected to the goals and strategies pursuant to Section 53591(a)(1).

(3) The amount requested shall not exceed the maximum amount specified in Section 208.

(4) The proposed projects shall be financially feasible for the duration of the HHC rental subsidy.

(5) A resolution from the County board of supervisors, or other controlling body, that authorizes the County to apply for funding and coordinate referrals and access to health care services to HHC tenants, such as a WPC pilot program, Health Homes Program, or other community-based program funding services.

(6) A County Application Plan as specified in Section 211.

(c) A County subrecipient(s) of HHC funds cannot be debarred or suspended from any state programs.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53592 and 53595.

Section 203. Eligible Uses

(a) A County shall use grants awarded pursuant to this part for any of the following:

(1) Acquisition, new construction, or reconstruction and rehabilitation of (a) project(s). Under this use, Applicants will be subject to Article I, Sections 103(a)(1), 104, 105, 106, 107, and 109(a) of these Guidelines.

(2) Operating assistance, which may include either or both of the following:

a. Long-term rental assistance to private landlords for periods as referenced in the NOFA, subject to renewal grants.

b. A Capitalized Operating Subsidy Reserve (COSR) for at least 15 years to pay for operating costs of an apartment or apartments receiving capital funding to provide Supportive housing to the Target Population.

(3) A County's administrative costs, as determined by the Department NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 204. Site and Neighborhood and Property Standard Requirements

In carrying out the site and neighborhood standards with respect to new construction, the requirements of 24 CFR 983.57(e)(2) apply. These standards do not apply to rehabilitation projects. However, if project-based vouchers are used in an assisted rehabilitation unit, the site and neighborhood standards for project-based vouchers will apply. In addition, the requirements of 24 CFR Part 8 will apply, and specifically address the site selection with respect to accessibility for persons with disabilities.

The Applicant shall ensure that all Assisted Units meet all applicable federal and state property standards. All Assisted Units must also meet the requirements of 25 CCR Section 8304 for the duration of the affordability period. Projects must meet the accessibility requirements specified in the TCAC regulations, as may be amended and renumbered from time to time, including those of Section 10325(f)(7)(K) and, for senior projects, those of Section 10325(g)(2)(B) and (C). Exemption requests, as provided for in the TCAC regulations, must be approved by the Department.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 205. Occupancy and Income Requirements

(a) Household income shall be determined in accordance with the rules in 24 CFR 93.151. At the time of move-in, household income shall not exceed the established extremely low income (ELI) limits or incomes at or below the poverty line, whichever is greater.

(b) The County or subrecipients shall maintain documentation of tenant income eligibility and eligibility in all the following ways, as applicable:

(1) Documentation of enrollment in or eligibility for Medi-Cal benefits.

(2) Documentation of a person's status as Chronically homeless could be captured through any of the following:
   a. A client's entry and exits documented in a Homeless Management Information System;
   b. An outreach worker or Case Manager's written observations; or
   c. A client's self-report of episodes of Homeless and disability status must be done in accordance with procedures established through the local Coordinated Entry System or other procedures established by the County for determining whether a person qualifies as a Homeless and High-cost health user, or Chronically homeless.

(3) Documentation of a person's status as a High-cost health user could be captured through any of the following:
   a. Discharge summaries; or
   b. An outreach worker's, case manager's or local County's health department written observations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 206. Rent Limits

(a) Assisted Unit rent shall not exceed the Fair Market Rent or reasonable market rent as determined by the Department. Tenants must meet the income determination requirements of Section 205.

(b) Over-income tenants - if at the time of re-certification, a tenant household's income exceeds the extremely low-income limit, or income at or below the poverty line, then the County/subrecipient:

(1) Shall re-designate the tenant's Assisted Unit as a non-Assisted Unit and designate the next available non-assisted comparable unit as an Assisted Unit until the unit mix required by the Program regulatory agreement is achieved.

(2) If all the project units are Assisted Units, that project can continue with the over-income unit(s) until such time as those over-income households no longer reside in the project.

(3) A unit shall be deemed "comparable" if it has the same number of bedrooms and reasonably similar square footage as the original unit.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 207. Capitalized Operating Subsidy Reserves (COSR)

HHC grant funds may be used to pay for a COSR with the following conditions:

(a) The COSR shall be sized to cover anticipated operating deficits attributable to the Assisted Units for a minimum of 15 years. The total amount of each project's operating reserves will be determined based upon the individual project underwriting performed by the County pursuant to the requirements of these Guidelines.

(b) In determining how to size each project's COSR, the County shall consider individual project factors, such as: the maximum percentage of Assisted Units it will assist; anticipated project vacancy rates; the anticipated percentage of Assisted Units that will have other operating subsidy and the term of that operating subsidy contract, and anticipated tenant incomes.

(c) The following standard assumptions will be used for establishing the total amount of a COSR. The Department may modify these assumptions as necessary to maintain project feasibility or extend the term of the operating reserves.

(1) All Assisted Units, other than the proportionate share of the manager's unit,

shall be counted in calculating the amount of COSR. An Assisted Unit receiving other rental assistance may receive assistance from a COSR.

(2) In projects of greater than 20 units, HHC will assist no more than 49 percent of the total project units. This limitation shall not be interpreted to preclude occupancy of any project units by persons with disabilities or restrictions by other funding sources, including but not limited to TCAC, that result in more than 49 percent of the total project units being restricted to the Target Population. It shall also not apply to projects complying with alternative requirements for demonstrating Olmstead compliance adopted by local jurisdictions and approved by the Department.

(3) In projects of 20 units or less, up to 100 percent of the units may be Assisted Units.

(4) The stabilized residential vacancy rate for the Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market or other evidence.

(d) Notwithstanding the above, in order to sustain the availability of a COSR for a minimum of 15 years, distributions from a COSR shall be subject to the following:

The County may not disburse more than 5 percent of the total COSR award made to a project per year, except that in any given year where the operating deficit attributable to the Assisted Units exceeds this amount, the Grantee may, in its sole discretion, increase the disbursement to up to 7 percent of the total COSR award, in accordance with the operating reserves limits and applicable review processes.

(e) Operating expenses that are eligible to be paid from a COSR include:

(1) Insurance

(2) Utilities

(3) Real property taxes

(4) Maintenance

(5) Supportive Services costs

(f) The statute/Guidelines do not preclude use of HHC funds on other supportive housing opportunities using capital and operating assistance, as long as the use of the funds is consistent with the requirements of Part 14.2 of Division 31 of the Health and Safety Code, as well as all other state, federal laws and regulations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 208. Maximum Award Limits

The maximum grant limit is $20,000,000 per Applicant for new construction, acquisition, rehabilitation, rental subsidies, administrative costs and/or operating assistance (COSR and/or rental assistance). The actual award amounts may be adjusted for project size and the number of households served.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 209. Fee Limits

A County may use up to 10 percent of the grant, as reflected in the NOFA, to fund administrative costs for the HHC program.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 210. Use of Operating Cash Flow

Regarding allowable uses of operating cash flow for capital or operating subsidies, including a COSR, the County shall follow the requirements commencing with 25 CCR Section 8314, as applicable.

Where there is a difference between the provisions of the UMRs and these Guidelines, the provisions of these Guidelines shall prevail.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 211. County Application Plan

Any plan that meets the following requirements is acceptable, including, but not limited to, Continuum of Care plans, or any other County plan specific to homelessness. Applicant's proposed uses of funds should be clearly connected to the goals and strategies outlined in the plan.

Applicants should include in their application plan the following:

(a) A description of homelessness County-wide, including a discussion of the estimated number of residents experiencing homelessness or chronic homelessness among single adults, families, and unaccompanied youth;

(b) Special challenges or barriers to serving the Target Population;

(c) County resources applied to address homelessness, including efforts undertaken to prevent the criminalization of activities associated with homelessness;

(d) Available community-based resources, including partnerships with community-based organizations and non-profits;

(e) Identification of other partners tasked with addressing Homeless needs;

(f) Systems in place to collect the data required under Section 219;

(g) Efforts that will be undertaken to ensure that access to a CES, and any alternate assessment and referral system established for the Target Population pursuant to the requirements of these Guidelines, will be available on a nondiscriminatory basis;

(h) Applicants may propose an alternative definition of High-cost health user than defined in Section 201 of these Guidelines.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53592 and 53595.

Section 212. Application Process

(a) The Department shall issue a NOFA that details the application process for Applicants that specifies, among other things, the amount of funds available, application requirements, threshold requirements, award requirements, the allocation of rating points, the deadline for submittal of applications, and other general terms and conditions of funding commitments.

(b) The Department shall evaluate applications for compliance with the minimum requirements set forth in Section 202 and score based on the criteria outlined in Section 213.

(c) Applicants that do not meet the minimum requirements will be rejected and will not be rated.

(d) The Department reserves the right to do the following:

(1) Score an application as submitted in the event information is missing from the application; and

(2) Request clarification of unclear or ambiguous statements made in an application and other supporting documents where doing so will not impact the competitive scoring of the application.

(e) Applications selected for funding shall be approved at amounts, terms, and conditions specified by the Guidelines and the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1).

Section 213. Application Selection Criteria

The criteria detailed below and summarized in the following table shall be used to rate applications.

	Maximum Applicable Points
Need	
Number of individuals experiencing homelessness and impact of housing costs (H&S Code 53591(a)(1)(A)	10
Applicant's commitment to address Homeless needs (H&S Code 53591(a)(1)(D)	15
Total Need Points	**25**
Proposed Uses and Process for Using Funds	
Project(s) Description (H&S Code 53591(a)(1)(F)	10
Process for Using Grant Funds (H&S Code 53591(a)(1)(B)	10
Funding Coordination (H&S Code 53591(a)(1)(C)	10
Total Uses of Funds Points	**30**
Experience	
Applicant's experience in rental subsidies, funding, underwriting, or administering Supportive housing projects	15
Applicant's experience with projects comparable in scope/services to proposed project	15
Barriers encountered and addressed	5
Identify any best practices that could be used by other program participants	5
Total Experience Points	**40**
Funding Sources	
Description of plan to sustain funding	30
Total Funding Sources Points	**30**
Incentive Points	
Applicant has Whole Person Care Pilot Program available or renewed, or has Health Homes Program, or has other County-controlled funding that provides similar services to the Target Population. H&S Code 53591(a)(1)(E)	10
Projects with locally committed funding for projects in an amount at least equivalent to requested HHC funding	10
Total Incentive Points	**20**
TOTAL APPLICABLE POINTS	**145**

(a) Need (25 points maximum)

Consideration will be given to the number of individuals experiencing homelessness and the impact of housing costs in the County. Estimated need will be based on the number of Homeless individuals established at the latest PIT count and rent burden in the Applicant's geographic jurisdiction according to the Comprehensive Housing Affordability Strategy (CHAS) data. Points will be awarded as follows:

(1) Estimated Need (10 points maximum)
   a. More than 400 individuals are Homeless in the Applicant's geographic jurisdiction as stated in the NOFA (10 points); or
   b. More than half of the ELI population in the Applicant's geographic jurisdiction pay more than 50 percent of their income towards rent. (5 points)

(2) Describe the Applicant's demonstrated commitment to address the needs of people experiencing homelessness. Applicant has demonstrated successful outcomes in implementing federal and state programs addressing the needs of people experiencing homelessness, along with local commitment of resources. (15 points maximum)
   a. The Applicant has dedicated local resources to provide Permanent housing to residents experiencing homelessness over the last three years and has a plan to address homelessness. The plan has been successful and has been implemented for at least one year (15 points); or
   b. The Applicant has administered programs with successful outcomes in moving people from homelessness to Permanent housing but has not dedicated resources consistently over the last three years. The Applicant has a plan to address homelessness and has been implementing it over the last year (10 points); or
   c. The Applicant proposes to implement some actions in the next 12 months, including implementation of a plan to address homelessness and dedication of local resources. (5 points)

(b) Proposed Uses and Process for Using Funds (30 points maximum)

(1) Project Description. Applicant's description of the specific uses of the grant funds. For each specific planned use of the grant funds, the Applicant must respond to the required items to receive full points: (10 points)
   a. If the Applicant intends to use funding for development, project(s)' location and target date(s) for completion (10 points); or
   b. If the Applicant intends to use funding for rental assistance or a COSR, project(s)' total number of units and the total number of households who will receive Permanent housing and/or rental subsidies under the project (10 points).

(2) Process for Using Grant Funds. The Applicant's description of the following: (10 points maximum)
   a. The Applicant's or agency or agencies responsible for the distribution of the HHC grant funds and the proposed selection criteria and process to identify project(s) and/or sub-recipient(s) (6 points);

b. The timeline with clearly delineated milestones (1 point); and
c. The proposed funding source for the services (3 points)

(3) Funding Coordination. The Applicant's description of how the proposed HHC funding will supplement existing federal, state, and local funding. (10 points maximum)
a. Regarding service provision, the Applicant's description of the following:
1. The funding source(s) (2 points);
2. The amount of funding per participant, per month, the Applicant intends to commit (1 point);
3. The length of time services will be provided (1 point); and
4. The process for selecting the Homeless service provider (2 points).
b. The description of the Applicant's partnerships with affordable and Supportive housing providers to address homelessness (2 points).
c. The description of the Applicant's partnerships with healthcare providers who provide dental, mental health, primary care and substance abuse services (2 points).

(c) Experience (40 points maximum)

(1) The Applicant's experience, for the last three years, in funding and underwriting Supportive housing projects; and/or the Applicant's experience administering Supportive housing projects; and/or the Applicant's experience working with agencies that administer rental subsidies. (15 points maximum)
a. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered four or more projects in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 500 households in the last three years. (15 points)
b. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered at least two to three projects in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 300 households in the last three years. (10 points)
c. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered one project in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 100 households in the last three years. (5 points)

(2) The Applicant's development funding, rental assistance, or other operating assistance to the Target Population that is comparable in scale and scope to the number of projects or rental assistance the Applicant has proposed for the Program. (15 points maximum)
a. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered four or more projects comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance,

the administering agency has administered rental subsidies for at least 500 clients similar to the Target Population. (15 points)

b. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered at least two to three projects comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 300 clients similar to the Target Population. (10 points)

c. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered one project comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 100 clients similar to the Target Population. (5 points)

(3) Description of barrier(s) the Applicant encountered in the implementation of its Homeless strategy or funding and how barriers were resolved. (5 points)

(4) Description of any best practices developed by the Applicant that could be used for other program participants. (5 points)

(d) Funding Sources (30 points maximum)

(1) The Applicant's description of the plan to sustain funding for the program/project. The Applicant may commit to using funding from the Building Homes & Jobs Act allocations to score points in this category. (30 points)

(e) Incentive Points (20 points maximum)

(1) The Applicant has a Whole Person Care Pilot Program or is working with managed care organizations to make available Health Homes Program benefits to people experiencing homelessness. (10 points)

(2) Evidence demonstrating locally committed funding in an amount at least equivalent to requested HHC funding. (10 points)

In the event of tied point scores, the following tiebreakers shall be used to determine which project is selected for funding, in the order listed:

(1) Applicant relevant experience

(2) Need

(3) Application Plan

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1).

Section 214. Supportive Services

(a) Each application must include a County-specific Supportive Services plan that will identify how the County plans to provide or subcontract to provide Supportive Services to participants in the Program.

(b) The County must ensure services are provided to participants, but that participants are not required to participate in services. Access to or continued occupancy in housing cannot be conditioned on participation in services or on sobriety. The Supportive Services plan must describe the services to be made available to HHC tenants in a manner that is voluntary, flexible, and individualized, so HHC tenants may continue to engage with supportive services providers, even as the intensity of services needed may change. The level of services should support tenant engagement and housing retention.

(c) Using evidence-based models, the following Supportive Services shall be made available to HHC tenants based on tenant need. Except as otherwise noted below, the following required services shall be provided onsite at the project or offsite at another location easily accessible to tenants, with the majority of case management services offered on-site:

(1) Housing navigation to assist people experiencing homelessness to establish relationships with private landlords, if the County is using funding for rental assistance, and to apply for housing;

(2) Case management and tenancy support services;

(3) Peer support activities;

(4) Services to link participants, as needed, to behavioral health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups and to coordinate care;

(5) Services to link participants, as needed, to substance abuse disorder treatment;

(6) Support in linking to primary care services, including access to routine and preventive health and dental care, medication management, and wellness services;

(7) Benefits advocacy, including assistance or linkage to services in accessing Medi-Cal and Supplemental Security Income/State Supplementary Payment(SSI/SSP);

(8) Housing retention skills, including working with landlords and neighbors, unit maintenance and upkeep, and money management; and

(9) Services for persons with co-occurring mental and physical disabilities or co-occurring mental and substance use disorders not listed above.

The following Supportive Services are not required to be made available but are encouraged to be part of an Applicant's plan to provide Supportive Services to participants.

(1) Recreational and social activities;

(2) Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process;

(3) Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work; and

(4) Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

(d) The following additional information shall be provided in the Applicant's plan to provide Supportive Services:

(1) Description of tenant outreach, engagement, and retention strategies to be used;

(2) Description of each service to be offered, how services will be offered or provided depending upon who is anticipated to be providing the services, the location, and general hours of availability of the services;

(3) For services provided off-site, the plan must describe what public or private transportation options will be available to HHC tenants in order to provide them reasonable access to these services. Reasonable access is access that does not require walking more than one-half mile. Case management services should largely be provided on-site;

(4) Description of how the Supportive Services are culturally and linguistically competent for persons of different races, ethnicities, sexual orientations, gender identities, and gender expressions. This includes explaining how services will be provided to HHC tenants who do not speak English, or have other communication barriers, including sensory disabilities, and how communication among the services providers, the property manager, and these tenants will be facilitated;

(5) Estimated itemized budget, and sources of funding for services;

(6) Description of how the supportive services staff and property management staff or landlord will work together to prevent evictions, adopt and ensure compliance with harm reduction principles, and facilitate the implementation of reasonable accommodation policies from rent-up to ongoing operations of the project;

(7) General service provider and property manager communication protocols;

(8) Provider-to-client staff ratio (1:20);

(9) Description of how the physical design of the project fosters tenant engagement, onsite supportive services provision, safety and security, and sustainability of furnishings, equipment, and fixtures; and

(10) Other information needed by the Department to evaluate the Supportive Services to be offered consistent with the program, as specified in the NOFA.

The Department may request that any necessary updates to the plan to provide Supportive Services or related documents, including fully executed written agreements between the County, service providers, the project owner(s), if relevant, and the property manager, if relevant, be provided prior to the beginning of the initial rent-up period or prior to permanent loan closing, or after participants move into private-market apartments.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 215. Housing First

(a) Projects shall employ Housing First practices that are documented in the Applicant's plan to provide Supportive Services in the application. Projects must adhere to the Housing First core components pursuant to Welfare and Institutions Code Section 8255(b).

(b) Housing First practices include the following:

(1) Tenant selection practices that adhere to Section 216 of these Guidelines and promote the acceptance of Applicants regardless of their sobriety or use of substances, completion of treatment, or agreement to participate in services;

(2) Tenants are not rejected on the basis of poor credit or financial history, poor or lack of rental history, or minor criminal convictions;

(3) Tenants are assisted in making application for tenancy and reasonable accommodation requests;

(4) Supportive Services are flexible and voluntary and focus on housing stability, engagement, and problem-solving over therapeutic goals; and

(5) Landlords or property managers do not impose restrictions on daily activities or limiting privacy, visitors, or the individual's ability to engage freely in community activities.

(c) Management and services practices emphasize tenant retention and offer flexibility and services to prevent and resolve lease violations and evictions. Subsidy-only units

shall follow Housing First property management and services practices described in subsection (b) above or implement modified Housing First practices that, at a minimum, incorporate:

(1) Tenant selection practices that promote the acceptance of Applicants regardless of their sobriety or use of substances, completion of treatment, or agreement to participate in services;

(2) Applicants are seldom rejected on the basis of poor credit or financial history, poor or lack of rental history, or minor criminal convictions;

(3) Applicants are assisted in making application for tenancy and reasonable accommodation requests;

(4) Assistance shall be provided in obtaining Permanent housing as rapidly as possible and without preconditions, such as participation in services, length of stay, or successful completion of transitional housing program. Upon exit to Permanent housing, follow up services shall be provided for no less than six months to ensure that tenants retain Permanent housing; and

(d) Services are voluntary unless required by a public agency funding source.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 216. Tenant Selection

(a) Tenants must meet income requirements in Section 205 and Target Population requirements in Section 202.

(b) Tenants shall be selected through use of a CES, in accordance with the provisions of 25 CCR Section 8305 and in compliance with Housing First requirements consistent with the core components set forth in Welfare and Institutions Code Division 8

Chapter 6.5 Section 8255 subsection (b) and basic tenant protections established under federal, state, and local law.

(1) Reasonable selection criteria, as referred to in 25 CCR Section 8305(a)(1), shall include priority status under a local CES developed pursuant to 24 CFR 578.7(a)(8).

(2) If the CES existing in the County cannot refer persons in the Target Population, the alternative system used must prioritize those with the greatest needs among those for referral to available Assisted Units.

(3) Sponsors shall accept tenants regardless of sobriety, participation in services or treatment, history of incarceration, credit, or history of eviction in accordance with practices permitted pursuant to WIC Section 8255 or other federal or state project funding sources.

(c) The requirements of 25 CCR Sections 8305 (a)(4)(A) and 8305 (a)(4)(D) shall be implemented as approved by the Department in a manner that is consistent with the requirements of the CES.

(d) In communities that are not yet referring people experiencing homelessness to programs through CES, Applicants should describe the process of referring residents based on eligibility for the Program.

(e) Projects must also provide a preference for accessible units to persons with disabilities requiring the features of the accessible units in accordance with Section 10337(b)(2) of the TCAC regulations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 217. Rental Agreements and Grievance Procedures

Rental or occupancy agreements and grievance procedures for Assisted Units shall comply with 25 CCR Section 8307 and 24 CFR 93.303. Tenants shall not be required to maintain sobriety, be tested for substances, or participate in services or treatment.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 218. Vulnerable Populations Best Practices

The following best practices should be incorporated in the construction of projects that receive funding from HHC, to the extent possible. These best practices work to further the safety and physical and mental well-being of residents within a project.

(a) General best practices for all developments:

(1) Safety features:
   a. Site selection and development of the project should consider the safety concerns of the prospective tenants.
   b. Building entrance and exit points should only allow admittance to residents or guests that residents admit.
   c. Common areas within the project should be oriented so as to have:
      1. Two ways to enter or exit the area;
      2. Visibility to the area from outside of it, i.e. windows in walls or doors; and
      3. A centralized location, to the extent possible.
   d. Safety lighting that reduces or eliminates blind or dark spaces.

(2) Property Management:
   a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
   b. Post in common areas and annually review with tenants the project's

grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(b) For those populations that have a history of sexual trauma and/or domestic violence:

(1) Safety features incorporate all of the general best practices and include the following:

a. For projects that will also be serving women with a history of domestic violence or sexual trauma:

1. Designate at least 25 percent of the Assisted Units for women with a history of domestic violence or sexual trauma and/or women with children, thereby ensuring women are not a small minority of the tenancy.
2. Design projects to provide separate and secure floors, wings, or buildings for women with a history of domestic violence or sexual trauma and/or women with children. These separate and secure areas should restrict access to only the residents in the secured area.

b. Security cameras:

1. At entrances, exits and common areas (including hallways, elevators, and stair wells);
2. Written policy on the use of the cameras to specify who has access to see the videos, who monitors the surveillance, and under what conditions footage would be released to the authorities; and
3. Camera recordings should be maintained for at least 30 days.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(c) The project should have 24-hour security if it serves persons impacted by domestic violence, transition age youth and other vulnerable populations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 219. Reporting Requirements

The County shall, at annual and midyear intervals, report all of the following data to the Department:

(a) Not later than 90 days after the end of each project's fiscal year, the Grantee shall submit an independent audit of the development prepared by a certified public accountant and in accordance with the Department's current audit requirements and all other applicable requirements, as stated by law or included in the NOFA.

(b) The County shall submit the data as required by the Department to measure the costs and outcomes for each of its Assisted Units. The County shall work with service providers or other sub-recipients to gather the data.

(c) The County shall report on the sources of tenant referrals for the project and submit both client data and performance outcome data to the Department. Tenant data may include, but is not limited to, demographic information. Performance outcome data shall include, but is not limited to, information on housing stability, tenant satisfaction as measured in a survey, and changes in income and benefits received.

(d) The County shall also report on the following:

(1) The number of participants who have received assistance through the Program in that year, and the type of intervention the participant received with HHC funds;

(2) The number of participants living in Supportive housing or other Permanent housing with HHC funds, and exits from the program, and the reasons for the exits; and

(3) To the extent available and feasible, the County shall provide data on the impact of the Program on participant's use of corrections systems and law enforcement resources.

(e) Recipient must comply with 2 CFR Part 512, as outlined in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53593.

Section 220. Operating Budgets

The County shall submit proposed operating budgets to the Department prior to award and annually thereafter. These budgets shall be subject to Department approval and comply with the requirements in 25 CCR Section 7326.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594.

Section 221. Federal and State Overlays

(a) Federal Overlays. Activities funded with HHC funds are required to comply with 24 CFR Part 93.350 and 24 CFR Part 93.301. Compliance with these requirements include, but are not limited to, environmental provisions, federal Davis-Bacon Wage requirements and state prevailing wage laws, relocation, Equal Opportunity and Fair Housing, Fair Housing Amendments Act, Affirmative Marketing, Section 504 of the Rehabilitation Act and its implementing regulations, and the Americans with Disabilities Act and its implementing regulations, Section 3 (employment of low-income persons), Violence Against Women Act, and Single Audit report 2 CFR Part

200.512. Failure to comply with federal overlays could result in significant project cost increases, and rejection of the HHC application.

(b) State Overlays. Article XXXIV of the California Constitution requires local voter approval before any state public body can develop, construct, or acquire a low-rent housing project in any manner. However, the Public Housing Election Implementation Law (Health & Safety. Code, §§ 37000 – 37002) provides clarification as to when Article XXXIV is applicable.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

Section 222. Legal Documents

Grants shall be governed by a Standard Agreement or other agreement with the County on a form prescribed by the Department. The agreement shall ensure that the provisions of these Guidelines are applicable to the project(s) covered by the agreement and enforceable by the Department. The agreement will contain such other provisions as the Department determines are necessary to meet the requirements and goals of the program, including, but not limited to, the following:

(a) Requirements for the execution of a promissory note, operating reserve agreement, or other project-specific contracts as may be applicable;

(b) Requirements set forth in the NOFA;

(c) Requirements, where appropriate, for the execution and recordation of covenants, regulatory agreements, or other instruments restricting the use and occupancy of and appurtenant to the project and the property thereunder (for the purposes of these Guidelines, all such documents are collectively herein referred to as the HHC regulatory agreement);

(d) The County's responsibilities for timing and completion of Projects, if applicable, as well as any and all reporting requirements;

(e) Remedies available to the Department in the event of a violation, breach or default of the Standard Agreement; and

(f) Any and all other provisions necessary to ensure compliance with the requirements of HHC and applicable state and federal law.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

Section 223. Defaults and Grant Cancellations

In the event the Department becomes aware of a breach or violation by the Grantee or its participating entities engaged in the delivery of HHC, any of the provisions of HHC–SB 2 requirements or Standard Agreement, or the locally executed HHC loan or

grant pertaining to the project, the Department may give written notice to violators to cure the breach or violation within a period of not less than 15 days. If the breach or violation is not cured to the satisfaction of the Department within the specified time period, the Department, at its option, may declare a default under the relevant document(s) and may seek legal remedies for the default, including but not limited to the following:

(a) Termination of the Grant Agreement and full or partial repayment of the awarded amount.

(b) Suspension from future Department funding awards.

(c) The Department may seek other remedies set forth in the Grant Agreement or any other applicable legal or equitable remedies.

If the breach or violation involves charging tenants rent or other charges in excess of those permitted under the Standard Agreement, the Department may demand the return of such excess rents or other charges to the respective households. In any action to enforce the provisions of the Standard Agreement, the Department may seek, as an additional remedy, the repayment of such overcharges.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

A Public Agency

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Financial Summary

October 31, 2020

Board of Directors Meeting

December 3, 2020

Nancy Huang, Chief Financial Officer

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FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: ($2.0) million, favorable to budget $2.1 million or 50.6%
  - YTD: ($0.6) million, favorable to budget $6.3 million or 90.9%
- Enrollment
  - MTD: 797,477 members, favorable to budget 4,185 or 0.5%
  - YTD: 3,137,883 member months, favorable to budget 7,750 or 0.2%
- Revenue
  - MTD: $318.6 million, unfavorable to budget $4.7 million or 1.4% driven be Medi-Cal (MC) line of business (LOB):
    - $4.1 million of Whole Child Model (WCM) prior year (PY) revenue due to restated enrollment and calendar year (CY) 2019 Quality Withhold (QW) accrued revenue of $3.3 million
    - Offset by $13.2 million of Proposition 56 risk corridor estimate
  - YTD: $1.3 billion, favorable to budget $67.5 million or 5.3% driven by MC LOB:
    - Fiscal year (FY) 2019 hospital Directed Payments (DP)
    - Offset by bridge period Gross Medical Expense (GME) reduction and Proposition 56 risk corridor estimates

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FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $309.3 million, favorable to budget $6.3 million or 2.0%
    - Driven by MC LOB $7.4 million favorable variance due to decrease in utilization during COVID-19 pandemic
    - Offset by OneCare Connect (OCC) LOB $1.2 million unfavorable volume related variance
  - YTD: $1.3 billion, unfavorable to budget $64.5 million or 5.2%
    - Primarily driven by MC LOB FY 2019 hospital DP, offset by decrease in utilization during COVID-19 pandemic
- Administrative Expenses
  - MTD: $11.0 million, favorable to budget $1.9 million or 15.1%
  - YTD: $44.4 million, favorable to budget $7.0 million or 13.6%
- Net Investment & Other Income
  - MTD: ($0.3) million, unfavorable to budget $1.5 million or 121.5%
  - YTD: $1.4 million, unfavorable to budget $3.6 million or 72.9%

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FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 97.1%, Budget 97.7%
  - YTD: Actual 96.9% (96.6% excluding DP), Budget 96.9%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.4%, Budget 4.0%
  - YTD: Actual 3.3% (3.6% excluding DP), Budget 4.0%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.95
  - Net position: $1.0 billion, including required Tangible Net Equity (TNE) of $102.8 million

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Enrollment Summary: October 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
114,308	110,895	3,413	3.1%	SPD	452,862	443,344	9,518	2.1%
525	481	44	9.1%	BCCTP	2,063	1,948	115	5.9%
289,896	309,075	(19,179)	(6.2%)	TANF Child	1,159,276	1,214,102	(54,826)	(4.5%)
98,888	92,940	5,948	6.4%	TANF Adult	386,320	365,263	21,057	5.8%
4,900	3,511	1,389	39.6%	LTC	19,395	14,032	5,363	38.2%
257,940	248,610	9,330	3.8%	MCE	1,006,268	980,198	26,070	2.7%
14,286	11,932	2,354	19.7%	WCM	45,645	47,728	(2,083)	(4.4%)
780,743	**777,444**	**3,299**	**0.4%**	**Medi-Cal Total**	**3,071,829**	**3,066,615**	**5,214**	**0.2%**
14,720	**14,054**	**666**	**4.7%**	**OneCare Connect**	**58,255**	**56,375**	**1,880**	**3.3%**
1,627	**1,378**	**249**	**18.1%**	**OneCare**	**6,269**	**5,512**	**757**	**13.7%**
387	**416**	**(29)**	**(7.0%)**	**PACE**	**1,530**	**1,631**	**(101)**	**(6.2%)**
797,477	**793,293**	**4,185**	**0.5%**	**CalOptima Total**	**3,137,883**	**3,130,133**	**7,750**	**0.2%**

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Financial Highlights: October 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
797,477	793,292	4,185	0.5%	Member Months	3,137,883	3,130,133	7,750	0.2%
318,575,352	323,226,881	(4,651,529)	(1.4%)	Revenues	1,348,302,836	1,280,807,180	67,495,656	5.3%
309,348,949	315,638,243	6,289,294	2.0%	Medical Expenses	1,305,909,279	1,241,387,085	(64,522,194)	(5.2%)
10,972,825	12,919,827	1,947,002	15.1%	Administrative Expenses	44,378,380	51,373,604	6,995,224	13.6%
(1,746,421)	**(5,331,189)**	**3,584,768**	**67.2%**	**Operating Margin**	**(1,984,823)**	**(11,953,509)**	**9,968,686**	**83.4%**
(268,546)	1,250,000	(1,518,546)	(121.5%)	Non Operating Income (Loss)	1,352,613	5,000,000	(3,647,387)	(72.9%)
(2,014,967)	**(4,081,189)**	**2,066,222**	**50.6%**	**Change in Net Assets**	**(632,210)**	**(6,953,509)**	**6,321,299**	**90.9%**
97.1%	97.7%	0.5%		Medical Loss Ratio	96.9%	96.9%	0.1%	
3.4%	4.0%	0.6%		Administrative Loss Ratio	3.3%	4.0%	0.7%	
(0.5%)	(1.6%)	1.1%		Operating Margin Ratio	(0.1%)	(0.9%)	0.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
97.1%	97.7%	0.5%		*MLR (excluding Directed Payments)	96.6%	96.9%	0.3%	
3.4%	4.0%	0.6%		*ALR (excluding Directed Payments)	3.6%	4.0%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

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Consolidated Performance Actual vs. Budget: October 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.6)	(4.3)	1.6	Medi-Cal	(4.2)	(8.7)	4.5
(0.1)	(1.2)	1.1	OCC	(0.6)	(4.1)	3.5
0.3	0.0	0.3	OneCare	0.6	0.2	0.5
0.7	0.1	0.6	PACE	2.2	0.7	1.5
(1.7)	**(5.3)**	**3.6**	**Operating**	**(2.0)**	**(12.0)**	**10.0**
(0.3)	1.3	(1.5)	Inv./Rental Inc, MCO tax	1.4	5.0	(3.6)
(0.3)	**1.3**	**(1.5)**	**Non-Operating**	**1.4**	**5.0**	**(3.6)**
(2.0)	**(4.1)**	**2.1**	**TOTAL**	**(0.6)**	**(7.0)**	**6.3**

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Consolidated Revenue & Expenses: October 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,517	257,940	14,286	780,743	14,720	1,627	387	797,477
REVENUES								
Capitation Revenue	146,033,900	$ 110,641,524	$ 27,935,508	$ 284,610,932	$ 28,407,161	$ 2,273,754	$ 3,283,505	$ 318,575,352
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	146,033,900	110,641,524	27,935,508	284,610,932	28,407,161	2,273,754	3,283,505	318,575,352
MEDICAL EXPENSES								
Provider Capitation	37,401,933	44,827,336	9,637,961	91,867,230	13,357,045	591,704		105,815,980
Facilities	18,678,985	37,776,073	4,319,366	60,774,424	3,696,714	436,202	434,517	65,341,857
Ancillary	-	-	-	-	-	-	-	-
Professional Claims	19,740,558	8,937,277	619,891	29,297,727	950,822	59,209	739,634	31,047,392
Prescription Drugs	20,430,665	26,323,465	4,945,339	51,699,469	5,993,615	648,531	266,938	58,608,553
MLTSS	34,621,576	2,731,192	1,487,869	38,840,636	1,363,599	36,885	(79)	40,241,041
Medical Management	2,235,053	1,388,880	293,349	3,917,282	1,045,556	26,380	850,620	5,839,838
Quality Incentives	841,099	504,354	34,100	1,379,553	216,480		4,838	1,600,871
Reinsurance & Other	350,575	186,660	11,099	548,334	206,922		98,162	853,417
Total Medical Expenses	134,300,443	122,675,238	21,348,976	278,324,657	26,830,753	1,798,911	2,394,628	309,348,949
Medical Loss Ratio	92.0%	110.9%	76.4%	97.8%	94.5%	79.1%	72.9%	97.1%
GROSS MARGIN	**11,733,458**	**(12,033,714)**	**6,586,532**	**6,286,276**	**1,576,408**	**474,843**	**888,877**	**9,226,403**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,735,749	718,355	77,877	157,556	7,689,537
Professional fees				(9,332)	93,104	16,000	123	99,895
Purchased services				749,972	99,901	14,380	31,375	895,627
Printing & Postage				175,017	150,748	(12,953)	5,687	318,499
Depreciation & Amortization				275,399			2,018	277,417
Other expenses				1,280,439	66,946		4,560	1,351,945
Indirect cost allocation & Occupancy				(282,302)	578,790	39,333	4,084	339,906
Total Administrative Expenses				8,924,942	1,707,843	134,636	205,403	10,972,825
Admin Loss Ratio				3.1%	6.0%	5.9%	6.3%	3.4%
INCOME (LOSS) FROM OPERATIONS				(2,638,667)	(131,435)	340,207	683,474	(1,746,421)
INVESTMENT INCOME								30,942
TOTAL MCO TAX				(309,109)				(309,109)
TOTAL GRANT INCOME				9,563				9,563
OTHER INCOME				59				59
CHANGE IN NET ASSETS				**$ (2,938,154)**	**$ (131,435)**	**$ 340,207**	**$ 683,474**	**$ (2,014,967)**
BUDGETED CHANGE IN NET ASSETS				(4,263,897)	(1,221,261)	36,538	117,431	(4,081,189)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,325,743	$ 1,089,826	$ 303,669	$ 566,043	$ 2,066,222

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Consolidated Revenue & Expenses: October 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,019,916	1,006,268	45,645	3,071,829	58,255	6,269	1,530	3,137,883
REVENUES								
Capitation Revenue	653,975,182	$ 468,965,337	$ 89,222,645	$ 1,212,163,164	$ 115,142,854	$ 8,168,004	$ 12,828,814	$ 1,348,302,836
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	653,975,182	468,965,337	89,222,645	1,212,163,164	115,142,854	8,168,004	12,828,814	1,348,302,836
MEDICAL EXPENSES								
Provider Capitation	144,173,225	172,441,691	41,616,082	358,230,998	51,225,093	2,196,907		411,652,998
Facilities	93,206,701	107,087,886	12,586,850	212,881,438	17,849,616	1,776,914	2,611,032	235,119,000
Professional Claims	78,181,474	36,346,349	3,978,401	118,506,224	3,884,622	296,959	2,425,835	125,113,640
Prescription Drugs	82,219,882	101,351,999	15,251,787	198,823,668	25,009,588	2,384,004	1,136,643	227,353,903
MLTSS	144,574,976	11,691,485	7,975,350	164,241,810	5,834,325	110,271	(9,952)	170,176,454
Medical Management	9,187,588	5,496,711	1,172,260	15,856,558	4,239,116	145,528	3,343,148	23,584,351
Quality Incentives	3,405,014	2,010,862	134,639	5,550,516	862,185		19,125	6,431,826
Reinsurance & Other	58,357,928	47,022,405	52,370	105,432,702	603,559		440,845	106,477,106
Total Medical Expenses	613,306,789	483,449,388	82,767,738	1,179,523,915	109,508,105	6,910,583	9,966,677	1,305,909,279
Medical Loss Ratio	93.8%	103.1%	92.8%	97.3%	95.1%	84.6%	77.7%	96.9%
GROSS MARGIN	**40,668,393**	**(14,484,051)**	**6,454,907**	**32,639,249**	**5,634,749**	**1,257,422**	**2,862,137**	**42,393,557**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				26,819,127	2,892,839	339,573	568,679	30,620,219
Professional fees				779,973	109,104	64,000	533	953,610
Purchased services				2,797,974	358,317	31,711	39,539	3,227,542
Printing & Postage				762,640	337,664	15,596	60,816	1,176,716
Depreciation & Amortization				1,151,954			8,143	1,160,097
Other expenses				5,561,716	181,780	205	13,398	5,757,099
Indirect cost allocation & Occupancy				(1,002,992)	2,315,161	157,330	13,598	1,483,097
Total Administrative Expenses				36,870,394	6,194,865	608,416	704,706	44,378,380
Admin Loss Ratio				3.0%	5.4%	7.4%	5.5%	3.3%
INCOME (LOSS) FROM OPERATIONS				(4,231,145)	(560,116)	649,006	2,157,431	(1,984,823)
INVESTMENT INCOME								3,374,088
TOTAL MCO TAX				(2,042,216)				(2,042,216)
TOTAL GRANT INCOME				20,475				20,475
OTHER INCOME				266				266
CHANGE IN NET ASSETS				**$ (6,252,620)**	**$ (560,116)**	**$ 649,006**	**$ 2,157,431**	**$ (632,210)**
BUDGETED CHANGE IN NET ASSETS				(8,724,815)	(4,097,095)	192,659	675,742	(6,953,509)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 2,472,195	$ 3,536,979	$ 456,347	$ 1,481,689	$ 6,321,299

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A Public Agency

Balance Sheet: As of October 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$255,029,409	Accounts Payable	$57,852,845
Investments	948,375,523	Medical Claims liability	921,395,163
Capitation receivable	337,770,621	Accrued Payroll Liabilities	13,959,020
Receivables - Other	50,004,412	Deferred Revenue	62,646,477
Prepaid expenses	5,711,104	Deferred Lease Obligations	149,857
		Capitation and Withholds	160,528,945
Total Current Assets	**1,596,891,068**	**Total Current Liabilities**	**1,216,532,307**
Capital Assets			
Furniture & Equipment	39,890,502		
Building/Leasehold Improvements	11,370,638		
505 City Parkway West	51,620,226		
	102,881,366		
Less: accumulated depreciation	(55,333,068)		
Capital assets, net	47,548,298	Other (than pensions) post employment benefits liability	25,993,822
Other Assets		Net Pension Liabilities	27,047,085
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,269,573,214**
Cash and Cash Equivalents	1,329,487		
Long-term Investments	585,820,736	**Deferred Inflows**	
Total Board-designated Assets	587,150,223	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
Total Other Assets	644,649,136	Change in Assumptions	3,728,725
		OPEB Changes in Assumptions	1,638,000
TOTAL ASSETS	**2,289,088,502**	**Net Position**	
		TNE	102,841,024
Deferred Outflows		Funds in Excess of TNE	921,658,063
Contributions	1,047,297	**TOTAL NET POSITION**	1,024,499,087
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	**2,300,749,572**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,300,749,572**

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Board Designated Reserve and TNE Analysis: As of October 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,686,805				
	Tier 1 - MetLife	159,452,401				
	Tier 1 - Wells Capital	159,798,341				
Board-designated Reserve		479,937,547	319,251,517	500,148,320	160,686,030	(20,210,773)
TNE Requirement	Tier 2 - MetLife	107,212,676	102,841,024	102,841,024	4,371,652	4,371,652
	Consolidated:	**587,150,223**	**422,092,541**	**602,989,344**	**165,057,683**	**(15,839,121)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

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CalOptima
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Our Mission

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

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CalOptima
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UNAUDITED FINANCIAL STATEMENTS

October 31, 2020

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CalOptima - Consolidated
Financial Highlights
For the Four Months Ended October 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
797,477	793,292	4,185	0.5%	Member Months	3,137,883	3,130,133	7,750	0.2%
318,575,352	323,226,881	(4,651,529)	(1.4%)	Revenues	1,348,302,836	1,280,807,180	67,495,656	5.3%
309,348,949	315,638,243	6,289,294	2.0%	Medical Expenses	1,305,909,279	1,241,387,085	(64,522,194)	(5.2%)
10,972,825	12,919,827	1,947,002	15.1%	Administrative Expenses	44,378,380	51,373,604	6,995,224	13.6%
(1,746,421)	**(5,331,189)**	**3,584,768**	**67.2%**	**Operating Margin**	**(1,984,823)**	**(11,953,509)**	**9,968,686**	**83.4%**
(268,546)	1,250,000	(1,518,546)	(121.5%)	Non Operating Income (Loss)	1,352,613	5,000,000	(3,647,387)	(72.9%)
(2,014,967)	**(4,081,189)**	**2,066,222**	**50.6%**	**Change in Net Assets**	**(632,210)**	**(6,953,509)**	**6,321,299**	**90.9%**
97.1%	97.7%	0.5%		Medical Loss Ratio	96.9%	96.9%	0.1%	
3.4%	4.0%	0.6%		Administrative Loss Ratio	3.3%	4.0%	0.7%	
(0.5%)	(1.6%)	1.1%		Operating Margin Ratio	(0.1%)	(0.9%)	0.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
97.1%	97.7%	0.5%		*MLR (excluding Directed Payments)	96.6%	96.9%	0.3%	
3.4%	4.0%	0.6%		*ALR (excluding Directed Payments)	3.6%	4.0%	0.4%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Four Months Ended October 31, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	780,743	777,444	3,299	0.4%
OneCare Connect	14,720	14,054	666	4.7%
OneCare	1,627	1,378	249	18.1%
PACE	387	416	(29)	(7.0%)
Total	797,477	793,292	4,185	0.5%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (2,938)	$ (4,264)	$ 1,326	31.1%
OneCare Connect	(131)	(1,221)	1,090	89.2%
OneCare	340	37	304	831.1%
PACE	683	117	566	482.0%
505 Bldg.	-	-	-	0.0%
Investment Income	31	1,250	(1,219)	(97.5%)
Total	$ (2,015)	$ (4,081)	$ 2,066	50.6%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.8%	97.7%	(0.1)
OneCare Connect	94.5%	98.4%	3.9
OneCare	79.1%	89.6%	10.5

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,925	$ 10,975	$ 2,050	18.7%
OneCare Connect	1,708	1,633	(74)	(4.6%)
OneCare	135	139	4	2.9%
PACE	205	173	(32)	(18.7%)
Total	$ 10,973	$ 12,920	$ 1,947	15.1%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,068	1,161	92
OneCare Connect	188	210	22
OneCare	10	9	(1)
PACE	91	116	25
Total	1,358	1,496	138

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	731	670	61
OneCare Connect	78	67	11
OneCare	161	148	12
PACE	4	4	1
Total	974	889	85

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	3,071,829	3,066,615	5,214	0.2%
OneCare Connect	58,255	56,375	1,880	3.3%
OneCare	6,269	5,512	757	13.7%
PACE	1,530	1,631	(101)	(6.2%)
Total	3,137,883	3,130,133	7,750	0.2%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (6,253)	$ (8,725)	$ 2,472	28.3%
OneCare Connect	(560)	(4,097)	3,537	86.3%
OneCare	649	193	456	236.3%
PACE	2,157	676	1,482	219.3%
505 Bldg.	-	-	-	0.0%
Investment Income	3,374	5,000	(1,626)	(32.5%)
Total	$ (632)	$ (6,954)	$ 6,321	90.9%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.3%	97.0%	(0.3)
OneCare Connect	95.1%	97.7%	2.6
OneCare	84.6%	89.0%	4.4

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 36,870	$ 43,667	$ 6,797	15.6%
OneCare Connect	6,195	6,502	307	4.7%
OneCare	608	552	(57)	(10.2%)
PACE	705	652	(52)	(8.0%)
Total	$ 44,378	$ 51,374	$ 6,995	13.6%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	4,340	4,643	303
OneCare Connect	763	839	76
OneCare	41	37	(3)
PACE	361	465	104
Total	5,503	5,984	481

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	708	660	47
OneCare Connect	76	67	9
OneCare	154	148	6
PACE	4	4	1
Total	943	879	63

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended October 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	797,477		793,292		4,185	
REVENUE						
Medi-Cal	$ 284,610,932	$ 364.54	$ 292,391,902	$ 376.09	$ (7,780,970)	$ (11.55)
OneCare Connect	28,407,161	1,929.83	25,771,528	1,833.75	2,635,633	96.08
OneCare	2,273,754	1,397.51	1,683,860	1,221.96	589,894	175.55
PACE	3,283,505	8,484.51	3,379,591	8,124.02	(96,086)	360.49
Total Operating Revenue	318,575,352	399.48	323,226,881	407.45	(4,651,529)	(7.97)
MEDICAL EXPENSES						
Medi-Cal	278,324,657	356.49	285,681,145	367.46	7,356,488	10.97
OneCare Connect	26,830,753	1,822.74	25,359,309	1,804.42	(1,471,444)	(18.32)
OneCare	1,798,911	1,105.66	1,508,699	1,094.85	(290,212)	(10.81)
PACE	2,394,628	6,187.67	3,089,090	7,425.70	694,462	1,238.03
Total Medical Expenses	309,348,949	387.91	315,638,243	397.88	6,289,294	9.97
GROSS MARGIN	9,226,403	11.57	7,588,638	9.57	1,637,765	2.00
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,689,537	9.64	8,169,316	10.30	479,779	0.66
Professional fees	99,895	0.13	369,342	0.47	269,447	0.34
Purchased services	895,627	1.12	1,273,451	1.61	377,824	0.49
Printing & Postage	318,499	0.40	569,734	0.72	251,235	0.32
Depreciation & Amortization	277,417	0.35	460,570	0.58	183,153	0.23
Other expenses	1,351,945	1.70	1,693,494	2.13	341,549	0.43
Indirect cost allocation & Occupancy expense	339,906	0.43	383,920	0.48	44,014	0.05
Total Administrative Expenses	10,972,825	13.76	12,919,827	16.29	1,947,002	2.53
INCOME (LOSS) FROM OPERATIONS	(1,746,421)	(2.19)	(5,331,189)	(6.72)	3,584,768	4.53
INVESTMENT INCOME						
Interest income	1,061,500	1.33	1,250,000	1.58	(188,500)	(0.25)
Realized gain/(loss) on investments	464,167	0.58	-	-	464,167	0.58
Unrealized gain/(loss) on investments	(1,494,725)	(1.87)	-	-	(1,494,725)	(1.87)
Total Investment Income	30,942	0.04	1,250,000	1.58	(1,219,058)	(1.54)
TOTAL MCO TAX	(309,109)	(0.39)	-	-	(309,109)	(0.39)
TOTAL GRANT INCOME	9,563	0.01	-	-	9,563	0.01
OTHER INCOME	59	-	-	-	59	-
CHANGE IN NET ASSETS	**(2,014,967)**	**(2.53)**	**(4,081,189)**	**(5.14)**	**2,066,222**	**2.61**
MEDICAL LOSS RATIO	**97.1%**		**97.7%**		**0.5%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.0%**		**0.6%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	3,137,883		3,130,133		7,750	
REVENUE						
Medi-Cal	$ 1,212,163,164	$ 394.61	$ 1,157,190,615	$ 377.35	$ 54,972,549	$ 17.26
OneCare Connect	115,142,854	1,976.53	103,606,775	1,837.81	11,536,079	138.72
OneCare	8,168,004	1,302.92	6,751,937	1,224.95	1,416,067	77.97
PACE	12,828,814	8,384.85	13,257,853	8,128.67	(429,039)	256.18
Total Operating Revenue	1,348,302,836	429.69	1,280,807,180	409.19	67,495,656	20.50
MEDICAL EXPENSES						
Medi-Cal	1,179,523,915	383.98	1,122,248,145	365.96	(57,275,770)	(18.02)
OneCare Connect	109,508,105	1,879.81	101,201,839	1,795.15	(8,306,266)	(84.66)
OneCare	6,910,583	1,102.34	6,007,386	1,089.87	(903,197)	(12.47)
PACE	9,966,677	6,514.17	11,929,715	7,314.36	1,963,038	800.19
Total Medical Expenses	1,305,909,279	416.18	1,241,387,085	396.59	(64,522,194)	(19.59)
GROSS MARGIN	42,393,557	13.51	39,420,095	12.60	2,973,462	0.91
ADMINISTRATIVE EXPENSES						
Salaries and benefits	30,620,219	9.76	32,353,074	10.34	1,732,855	0.58
Professional fees	953,610	0.30	1,477,368	0.47	523,758	0.17
Purchased services	3,227,542	1.03	5,105,055	1.63	1,877,513	0.60
Printing & Postage	1,176,716	0.38	2,278,936	0.73	1,102,220	0.35
Depreciation & Amortization	1,160,097	0.37	1,842,280	0.59	682,183	0.22
Other expenses	5,757,099	1.83	6,776,220	2.16	1,019,121	0.33
Indirect cost allocation & Occupancy expense	1,483,097	0.47	1,540,671	0.49	57,574	0.02
Total Administrative Expenses	44,378,380	14.14	51,373,604	16.41	6,995,224	2.27
INCOME (LOSS) FROM OPERATIONS	(1,984,823)	(0.63)	(11,953,509)	(3.82)	9,968,686	3.19
INVESTMENT INCOME						
Interest income	4,738,490	1.51	5,000,000	1.60	(261,510)	(0.09)
Realized gain/(loss) on investments	2,782,467	0.89	-	-	2,782,467	0.89
Unrealized gain/(loss) on investments	(4,146,870)	(1.32)	-	-	(4,146,870)	(1.32)
Total Investment Income	3,374,088	1.08	5,000,000	1.60	(1,625,912)	(0.52)
TOTAL MCO TAX	(2,042,216)	(0.65)	-	-	(2,042,216)	(0.65)
TOTAL GRANT INCOME	20,475	0.01	-	-	20,475	0.01
OTHER INCOME	266	-	-	-	266	-
CHANGE IN NET ASSETS	**(632,210)**	**(0.20)**	**(6,953,509)**	**(2.22)**	**6,321,299**	**2.02**
MEDICAL LOSS RATIO	**96.9%**		**96.9%**		**0.1%**	
ADMINISTRATIVE LOSS RATIO	**3.3%**		**4.0%**		**0.7%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended October 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	508,517	257,940	14,286	780,743	14,720	1,627	387	797,477
REVENUES								
Capitation Revenue	146,033,900	$ 110,641,524	$ 27,935,508	$ 284,610,932	$ 28,407,161	$ 2,273,754	$ 3,283,505	$ 318,575,352
Total Operating Revenue	146,033,900	110,641,524	27,935,508	284,610,932	28,407,161	2,273,754	3,283,505	318,575,352
MEDICAL EXPENSES								
Provider Capitation	37,401,933	44,827,336	9,637,961	91,867,230	13,357,045	591,704		105,815,980
Facilities	18,678,985	37,776,073	4,319,366	60,774,424	3,696,714	436,202	434,517	65,341,857
Ancillary	-	-	-	-	-	-	-	-
Professional Claims	19,740,558	8,937,277	619,891	29,297,727	950,822	59,209	739,634	31,047,392
Prescription Drugs	20,430,665	26,323,465	4,945,339	51,699,469	5,993,615	648,531	266,938	58,608,553
MLTSS	34,621,576	2,731,192	1,487,869	38,840,636	1,363,599	36,885	(79)	40,241,041
Medical Management	2,235,053	1,388,880	293,349	3,917,282	1,045,556	26,380	850,620	5,839,838
Quality Incentives	841,099	504,354	34,100	1,379,553	216,480		4,838	1,600,871
Reinsurance & Other	350,575	186,660	11,099	548,334	206,922		98,162	853,417
Total Medical Expenses	134,300,443	122,675,238	21,348,976	278,324,657	26,830,753	1,798,911	2,394,628	309,348,949
Medical Loss Ratio	92.0%	110.9%	76.4%	97.8%	94.5%	79.1%	72.9%	97.1%
GROSS MARGIN	**11,733,458**	**(12,033,714)**	**6,586,532**	**6,286,276**	**1,576,408**	**474,843**	**888,877**	**9,226,403**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,735,749	718,355	77,877	157,556	7,689,537
Professional fees				(9,332)	93,104	16,000	123	99,895
Purchased services				749,972	99,901	14,380	31,375	895,627
Printing & Postage				175,017	150,748	(12,953)	5,687	318,499
Depreciation & Amortization				275,399			2,018	277,417
Other expenses				1,280,439	66,946		4,560	1,351,945
Indirect cost allocation & Occupancy				(282,302)	578,790	39,333	4,084	339,906
Total Administrative Expenses				8,924,942	1,707,843	134,636	205,403	10,972,825
Admin Loss Ratio				3.1%	6.0%	5.9%	6.3%	3.4%
INCOME (LOSS) FROM OPERATIONS				(2,638,667)	(131,435)	340,207	683,474	(1,746,421)
INVESTMENT INCOME								30,942
TOTAL MCO TAX				(309,109)				(309,109)
TOTAL GRANT INCOME				9,563				9,563
OTHER INCOME				59				59
CHANGE IN NET ASSETS				**$ (2,938,154)**	**$ (131,435)**	**$ 340,207**	**$ 683,474**	**$ (2,014,967)**
BUDGETED CHANGE IN NET ASSETS				(4,263,897)	(1,221,261)	36,538	117,431	(4,081,189)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,325,743	$ 1,089,826	$ 303,669	$ 566,043	$ 2,066,222

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ended October 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,019,916	1,006,268	45,645	3,071,829	58,255	6,269	1,530	3,137,883
REVENUES								
Capitation Revenue	653,975,182	$ 468,965,337	$ 89,222,645	$ 1,212,163,164	$ 115,142,854	$ 8,168,004	$ 12,828,814	$ 1,348,302,836
Total Operating Revenue	653,975,182	468,965,337	89,222,645	1,212,163,164	115,142,854	8,168,004	12,828,814	1,348,302,836
MEDICAL EXPENSES								
Provider Capitation	144,173,225	172,441,691	41,616,082	358,230,998	51,225,093	2,196,907		411,652,998
Facilities	93,206,701	107,087,886	12,586,850	212,881,438	17,849,616	1,776,914	2,611,032	235,119,000
Professional Claims	78,181,474	36,346,349	3,978,401	118,506,224	3,884,622	296,959	2,425,835	125,113,640
Prescription Drugs	82,219,882	101,351,999	15,251,787	198,823,668	25,009,588	2,384,004	1,136,643	227,353,903
MLTSS	144,574,976	11,691,485	7,975,350	164,241,810	5,834,325	110,271	(9,952)	170,176,454
Medical Management	9,187,588	5,496,711	1,172,260	15,856,558	4,239,116	145,528	3,343,148	23,584,351
Quality Incentives	3,405,014	2,010,862	134,639	5,550,516	862,185		19,125	6,431,826
Reinsurance & Other	58,357,928	47,022,405	52,370	105,432,702	603,559		440,845	106,477,106
Total Medical Expenses	613,306,789	483,449,388	82,767,738	1,179,523,915	109,508,105	6,910,583	9,966,677	1,305,909,279
Medical Loss Ratio	93.8%	103.1%	92.8%	97.3%	95.1%	84.6%	77.7%	96.9%
GROSS MARGIN	**40,668,393**	**(14,484,051)**	**6,454,907**	**32,639,249**	**5,634,749**	**1,257,422**	**2,862,137**	**42,393,557**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				26,819,127	2,892,839	339,573	568,679	30,620,219
Professional fees				779,973	109,104	64,000	533	953,610
Purchased services				2,797,974	358,317	31,711	39,539	3,227,542
Printing & Postage				762,640	337,664	15,596	60,816	1,176,716
Depreciation & Amortization				1,151,954			8,143	1,160,097
Other expenses				5,561,716	181,780	205	13,398	5,757,099
Indirect cost allocation & Occupancy				(1,002,992)	2,315,161	157,330	13,598	1,483,097
Total Administrative Expenses				36,870,394	6,194,865	608,416	704,706	44,378,380
Admin Loss Ratio				3.0%	5.4%	7.4%	5.5%	3.3%
INCOME (LOSS) FROM OPERATIONS				(4,231,145)	(560,116)	649,006	2,157,431	(1,984,823)
INVESTMENT INCOME								3,374,088
TOTAL MCO TAX				(2,042,216)				(2,042,216)
TOTAL GRANT INCOME				20,475				20,475
OTHER INCOME				266				266
CHANGE IN NET ASSETS				**$ (6,252,620)**	**$ (560,116)**	**$ 649,006**	**$ 2,157,431**	**$ (632,210)**
BUDGETED CHANGE IN NET ASSETS				(8,724,815)	(4,097,095)	192,659	675,742	(6,953,509)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 2,472,195	$ 3,536,979	$ 456,347	$ 1,481,689	$ 6,321,299

October 31, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is ($2.0) million, $2.1 million favorable to budget
- Operating deficit is $1.7 million, with a deficit in non-operating income of $0.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is ($0.6) million, $6.3 million favorable to budget
- Operating deficit is ($2.0) 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				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.6)	(4.3)	1.6	Medi-Cal	(4.2)	(8.7)	4.5
(0.1)	(1.2)	1.1	OCC	(0.6)	(4.1)	3.5
0.3	0.0	0.3	OneCare	0.6	0.2	0.5
0.7	0.1	0.6	PACE	2.2	0.7	1.5
(1.7)	**(5.3)**	**3.6**	**Operating**	**(2.0)**	**(12.0)**	**10.0**
(0.3)	1.3	(1.5)	Inv./Rental Inc, MCO tax	1.4	5.0	(3.6)
(0.3)	**1.3**	**(1.5)**	**Non-Operating**	**1.4**	**5.0**	**(3.6)**
(2.0)	**(4.1)**	**2.1**	**TOTAL**	**(0.6)**	**(7.0)**	**6.3**

CalOptima - Consolidated
Enrollment Summary
For the Four Months Ended October 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
114,308	110,895	3,413	3.1%	SPD	452,862	443,344	9,518	2.1%
525	481	44	9.1%	BCCTP	2,063	1,948	115	5.9%
289,896	309,075	(19,179)	(6.2%)	TANF Child	1,159,276	1,214,102	(54,826)	(4.5%)
98,888	92,940	5,948	6.4%	TANF Adult	386,320	365,263	21,057	5.8%
4,900	3,511	1,389	39.6%	LTC	19,395	14,032	5,363	38.2%
257,940	248,610	9,330	3.8%	MCE	1,006,268	980,198	26,070	2.7%
14,286	11,932	2,354	19.7%	WCM	45,645	47,728	(2,083)	(4.4%)
780,743	**777,444**	**3,299**	**0.4%**	**Medi-Cal Total**	**3,071,829**	**3,066,615**	**5,214**	**0.2%**
14,720	**14,054**	**666**	**4.7%**	**OneCare Connect**	**58,255**	**56,375**	**1,880**	**3.3%**
1,627	**1,378**	**249**	**18.1%**	**OneCare**	**6,269**	**5,512**	**757**	**13.7%**
387	**416**	**(29)**	**(7.0%)**	**PACE**	**1,530**	**1,631**	**(101)**	**(6.2%)**
797,477	**793,293**	**4,185**	**0.5%**	**CalOptima Total**	**3,137,883**	**3,130,133**	**7,750**	**0.2%**

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	10,583	10,588	10,639									42,346	41,420	926
BCCTP	1	1	1	1									4	4	0
TANF Child	54,644	55,088	55,115	55,276									220,123	228,919	(8,796)
TANF Adult	29,033	29,687	30,001	30,679									119,400	115,309	4,091
LTC	(1)	402	197	215									813	8	805
MCE	74,441	75,955	76,054	78,435									304,885	290,569	14,316
WCM	1,721	1,726	2,086	2,507									8,040	8,180	(140)
Total	**170,375**	**173,442**	**174,042**	**177,752**									**695,611**	**684,409**	**11,202**
PHCs															
SPD	7,145	7,205	6,855	6,760									27,965	28,090	(125)
BCCTP													-		0
TANF Child	149,810	151,008	148,874	150,336									600,028	626,674	(26,646)
TANF Adult	11,688	12,097	12,071	12,492									48,348	45,177	3,171
LTC		158	81	65									304	4	300
MCE	39,815	40,711	39,935	41,371									161,832	155,456	6,376
WCM	5,625	5,716	7,990	8,497									27,828	28,732	(904)
Total	**214,083**	**216,895**	**215,806**	**219,521**									**866,305**	**884,133**	**(17,828)**
Shared Risk Groups															
SPD	10,264	10,312	10,068	10,117									40,761	40,625	136
BCCTP													-		0
TANF Child	58,289	58,687	57,269	58,133									232,378	252,680	(20,302)
TANF Adult	28,914	29,648	29,235	30,414									118,211	115,896	2,315
LTC	1	365	178	209									753	8	745
MCE	82,747	84,907	83,063	87,432									338,149	332,569	5,580
WCM	924	1,000	1,954	2,189									6,067	6,771	(704)
Total	**181,139**	**184,919**	**181,767**	**188,494**									**736,319**	**748,549**	**(12,230)**
Fee for Service (Dual)															
SPD	74,615	75,198	75,269	76,815									301,897	293,806	8,091
BCCTP	12	17	18	18									65	68	(3)
TANF Child	1	1	1	1									4	8	(4)
TANF Adult	909	1,266	994	1,107									4,276	3,891	385
LTC	3,079	4,461	3,855	3,838									15,233	12,640	2,593
MCE	1,658	1,859	1,948	2,077									7,542	5,679	1,863
WCM	13	17	16	17									63	52	11
Total	**80,287**	**82,819**	**82,101**	**83,873**									**329,080**	**316,144**	**12,936**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822	10,264	9,977									39,893	39,403	490
BCCTP	497	492	499	506									1,994	1,876	118
TANF Child	25,494	27,007	28,092	26,150									106,743	105,821	922
TANF Adult	23,028	24,014	24,847	24,196									96,085	84,990	11,095
LTC	351	788	580	573									2,292	1,372	920
MCE	45,498	47,292	52,445	48,625									193,860	195,925	(2,065)
WCM	791	806	974	1,076									3,647	3,993	(346)
Total	**105,489**	**110,221**	**117,701**	**111,103**									**444,514**	**433,380**	**11,134**
SPD	112,390	113,120	113,044	114,308									452,862	443,344	9,518
BCCTP	510	510	518	525									2,063	1,948	115
TANF Child	288,238	291,791	289,351	289,896									1,159,276	1,214,102	(54,826)
TANF Adult	93,572	96,712	97,148	98,888									386,320	365,263	21,057
LTC	3,430	6,174	4,891	4,900									19,395	14,032	5,363
MCE	244,159	250,724	253,445	257,940									1,006,268	980,198	26,070
WCM	9,074	9,265	13,020	14,286									45,645	47,728	(2,083)
Total Medi-Cal MM	**751,373**	**768,296**	**771,417**	**780,743**									**3,071,829**	**3,066,615**	**5,214**
OneCare Connect	**14,465**	**14,541**	**14,529**	**14,720**									**58,255**	**56,375**	**1,880**
OneCare	**1,525**	**1,523**	**1,594**	**1,627**									**6,269**	**5,512**	**757**
PACE	**382**	**381**	**380**	**387**									**1,530**	**1,631**	**(101)**
Grand Total	**767,745**	**784,741**	**787,920**	**797,477**									**3,137,883**	**3,130,133**	**7,750**

ENROLLMENT:

Overall, October enrollment was 797,477

- Favorable to budget 4,185 or 0.5%
- Increased 9,557 or 1.2% from prior month (PM) (September 2020)
- Increased 54,012 or 7.3% from prior year (PY) (October 2019)

Medi-Cal enrollment was 780,743

- Favorable to budget 3,299 or 0.4%
  - Medi-Cal Expansion (MCE) favorable 9,330
  - Seniors and Persons with Disabilities (SPD) favorable 3,413
  - Whole Child Model (WCM) favorable 2,354 due to retroactive enrollment of 2,139
  - Long-Term Care (LTC) favorable 1,389
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 44
  - Temporary Assistance for Needy Families (TANF) unfavorable 13,231
- Increased 9,326 from PM

OneCare Connect enrollment was 14,720

- Favorable to budget 666 or 4.7%
- Increased 191 from PM

OneCare enrollment was 1,627

- Favorable to budget 249 or 18.1%
- Increased 33 from PM

PACE enrollment was 387

- Unfavorable to budget 29 or 7.0%
- Increased 7 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
780,743	**777,444**	**3,299**	**0.4%**	**Member Months**	**3,071,829**	**3,066,615**	**5,214**	**0.2%**
				Revenues				
284,610,932	292,391,902	(7,780,970)	(2.7%)	Capitation Revenue	1,212,163,164	1,157,190,615	54,972,549	4.8%
284,610,932	**292,391,902**	**(7,780,970)**	**(2.7%)**	**Total Operating Revenue**	**1,212,163,164**	**1,157,190,615**	**54,972,549**	**4.8%**
				Medical Expenses				
93,246,784	98,987,597	5,740,813	5.8%	Provider Capitation	363,781,514	390,248,683	26,467,169	6.8%
60,774,424	59,087,443	(1,686,981)	(2.9%)	Facilities Claims	212,881,438	231,210,253	18,328,815	7.9%
29,297,727	33,391,722	4,093,995	12.3%	Professional Claims	118,506,224	130,946,141	12,439,917	9.5%
51,699,469	47,628,273	(4,071,196)	(8.5%)	Prescription Drugs	198,823,668	186,197,336	(12,626,332)	(6.8%)
38,840,636	40,852,644	2,012,008	4.9%	MLTSS	164,241,810	161,490,025	(2,751,785)	(1.7%)
3,917,282	5,129,460	1,212,178	23.6%	Medical Management	15,856,558	19,739,681	3,883,123	19.7%
548,334	604,006	55,672	9.2%	Reinsurance & Other	105,432,702	2,416,026	(103,016,676)	(4263.9%)
278,324,657	**285,681,145**	**7,356,488**	**2.6%**	**Total Medical Expenses**	**1,179,523,915**	**1,122,248,145**	**(57,275,770)**	**(5.1%)**
6,286,276	**6,710,757**	**(424,481)**	**(6.3%)**	**Gross Margin**	**32,639,249**	**34,942,470**	**(2,303,221)**	**(6.6%)**
				Administrative Expenses				
6,735,749	7,153,857	418,108	5.8%	Salaries, Wages & Employee Benefits	26,819,127	28,363,293	1,544,166	5.4%
(9,332)	313,093	322,425	103.0%	Professional Fees	779,973	1,252,372	472,399	37.7%
749,972	1,142,513	392,541	34.4%	Purchased Services	2,797,974	4,581,303	1,783,329	38.9%
175,017	443,433	268,416	60.5%	Printing and Postage	762,640	1,773,732	1,011,092	57.0%
275,399	458,500	183,101	39.9%	Depreciation & Amortization	1,151,954	1,834,000	682,046	37.2%
1,280,439	1,672,505	392,066	23.4%	Other Operating Expenses	5,561,716	6,694,372	1,132,656	16.9%
(282,302)	(209,247)	73,055	34.9%	Indirect Cost Allocation, Occupancy Expense	(1,002,992)	(831,787)	171,205	20.6%
8,924,942	**10,974,654**	**2,049,712**	**18.7%**	**Total Administrative Expenses**	**36,870,394**	**43,667,285**	**6,796,891**	**15.6%**
				Operating Tax				
12,159,641	15,053,405	(2,893,764)	(19.2%)	Tax Revenue	47,832,784	59,390,484	(11,557,700)	(19.5%)
12,468,750	15,053,405	2,584,655	17.2%	Premium Tax Expense	49,875,000	59,390,484	9,515,484	16.0%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
(309,109)	**-**	**(309,109)**	**0.0%**	**Total Net Operating Tax**	**(2,042,216)**	**-**	**(2,042,216)**	**0.0%**
				Grant Income				
68,643	-	68,643	0.0%	Grant Revenue	155,133	-	155,133	0.0%
54,188	-	(54,188)	0.0%	Grant expense - Service Partner	116,025	-	(116,025)	0.0%
4,893	-	(4,893)	0.0%	Grant expense - Administrative	18,633	-	(18,633)	0.0%
9,563	**-**	**9,563**	**0.0%**	**Total Grant Income**	**20,475**	**-**	**20,475**	**0.0%**
59	**-**	**59**	**0.0%**	**Other income**	**266**	**-**	**266**	**0.0%**
(2,938,154)	**(4,263,897)**	**1,325,743**	**31.1%**	**Change in Net Assets**	**(6,252,620)**	**(8,724,815)**	**2,472,195**	**28.3%**
97.8%	***97.7%***	***(0.1%)***	***(0.1%)***	***Medical Loss Ratio***	***97.3%***	***97.0%***	***(0.3%)***	***(0.3%)***
3.1%	***3.8%***	***0.6%***	***16.5%***	***Admin Loss Ratio***	***3.0%***	***3.8%***	***0.7%***	***19.4%***

MEDI-CAL INCOME STATEMENT – OCTOBER MONTH:

REVENUES of $284.6 million are unfavorable to budget $7.8 million driven by:

- Favorable volume related variance of $1.2 million
- Unfavorable price related variance of $9.0 million
  - $4.1 million of WCM revenue due to retroactive enrollment
  - Offset by $13.2 million of Proposition 56 risk corridor

MEDICAL EXPENSES of $278.3 million are favorable to budget $7.4 million driven by:

- Unfavorable volume related variance of $1.2 million
- Favorable price related variance of $8.6 million
  - Provider Capitation expense favorable variance of $6.2 million due to decreased utilization during COVID-19 pandemic
  - Professional Claims expense favorable variance of $4.2 million due to decreased utilization during COVID-19 pandemic
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $2.2 million due to decreased utilization during COVID-19 pandemic
  - Medical Management expense favorable variance of $1.2 million due to decreased utilization during COVID-19 pandemic
  - Offset by Prescription Drugs expense unfavorable variance of $3.9 million
  - Facilities Claims expense unfavorable variance of $1.4 million

ADMINISTRATIVE EXPENSES of $8.9 million are favorable to budget $2.0 million driven by:

- Salaries & Benefit expense favorable to budget $0.4 million
- Other Non-Salary expense favorable to budget $1.6 million

CHANGE IN NET ASSETS is ($2.9) million for the month, favorable to budget $1.3 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Four Months Ending October 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,720	**14,054**	**666**	**4.7%**	**Member Months**	**58,255**	**56,375**	**1,880**	**3.3%**
				Revenues				
2,807,694	2,713,157	94,537	3.5%	Medi-Cal Capitation Revenue	12,640,016	10,883,932	1,756,084	16.1%
21,473,021	17,847,998	3,625,023	20.3%	Medicare Capitation Revenue Part C	81,930,048	71,816,736	10,113,312	14.1%
4,126,446	5,210,373	(1,083,927)	(20.8%)	Medicare Capitation Revenue Part D	20,572,790	20,906,107	(333,317)	(1.6%)
28,407,161	**25,771,528**	**2,635,633**	**10.2%**	**Total Operating Revenue**	**115,142,854**	**103,606,775**	**11,536,079**	**11.1%**
				Medical Expenses				
13,573,525	11,369,168	(2,204,357)	(19.4%)	Provider Capitation	52,087,278	45,817,802	(6,269,476)	(13.7%)
3,696,714	4,063,899	367,185	9.0%	Facilities Claims	17,849,616	16,100,384	(1,749,232)	(10.9%)
950,822	953,037	2,215	0.2%	Ancillary	3,884,622	3,756,483	(128,139)	(3.4%)
1,363,599	1,557,022	193,423	12.4%	MLTSS	5,834,325	6,214,700	380,375	6.1%
5,993,615	5,968,716	(24,899)	(0.4%)	Prescription Drugs	25,009,588	23,585,924	(1,423,664)	(6.0%)
1,045,556	1,227,188	181,632	14.8%	Medical Management	4,239,116	4,862,208	623,092	12.8%
206,922	220,279	13,357	6.1%	Other Medical Expenses	603,559	864,338	260,779	30.2%
26,830,753	**25,359,309**	**(1,471,444)**	**(5.8%)**	**Total Medical Expenses**	**109,508,105**	**101,201,839**	**(8,306,266)**	**(8.2%)**
1,576,408	**412,219**	**1,164,189**	**282.4%**	**Gross Margin**	**5,634,749**	**2,404,936**	**3,229,813**	**134.3%**
				Administrative Expenses				
718,355	813,121	94,766	11.7%	Salaries, Wages & Employee Benefits	2,892,839	3,222,583	329,744	10.2%
93,104	40,083	(53,021)	(132.3%)	Professional Fees	109,104	160,332	51,228	32.0%
99,901	103,412	3,512	3.4%	Purchased Services	358,317	413,648	55,331	13.4%
150,748	106,517	(44,231)	(41.5%)	Printing and Postage	337,664	426,068	88,404	20.7%
66,946	16,855	(50,091)	(297.2%)	Other Operating Expenses	181,780	65,432	(116,348)	(177.8%)
578,790	553,492	(25,298)	(4.6%)	Indirect Cost Allocation	2,315,161	2,213,968	(101,193)	(4.6%)
1,707,843	**1,633,480**	**(74,363)**	**(4.6%)**	**Total Administrative Expenses**	**6,194,865**	**6,502,031**	**307,166**	**4.7%**
(131,435)	**(1,221,261)**	**1,089,826**	**89.2%**	**Change in Net Assets**	**(560,116)**	**(4,097,095)**	**3,536,979**	**86.3%**
94.5%	***98.4%***	***3.9%***	***4.0%***	***Medical Loss Ratio***	***95.1%***	***97.7%***	***2.6%***	***2.6%***
6.0%	***6.3%***	***0.3%***	***5.1%***	***Admin Loss Ratio***	***5.4%***	***6.3%***	***0.9%***	***14.3%***

ONECARE CONNECT INCOME STATEMENT– OCTOBER MONTH:

REVENUES of $28.4 million are favorable to budget $2.6 million driven by:

- Favorable volume related variance of $1.2 million
- Favorable price related variance of $1.4 million due to:
  - Calendar year (CY) 2019 Quality Withhold (QW) accrued revenue of $3.3 million
  - Offset by CY 2019 Part D risk sharing reserve adjustment of $1.4 million

MEDICAL EXPENSES of $26.8 million are unfavorable to budget $1.5 million driven by:

- Unfavorable volume related variance of $1.2 million
- Unfavorable price related variance of $0.3 million
  - Provider Capitation expense unfavorable variance of $1.7 million due to CY 2019 QW payable to the Health Networks (HN)
  - Offset by Facilities Claims expense favorable variance of $0.6 million
  - MLTSS expense favorable variance of $.03 million
  - Prescription drug expense favorable variance of $0.3 million
  - Medical Management expense favorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.7 million are unfavorable to budget $0.1 million

CHANGE IN NET ASSETS is ($0.1) million, favorable to budget $1.1 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,627	**1,378**	**249**	**18.1%**	**Member Months**	**6,269**	**5,512**	**757**	**13.7%**
				Revenues				
1,466,177	1,146,774	319,403	27.9%	Medicare Part C revenue	5,508,202	4,603,293	904,909	19.7%
807,577	537,086	270,491	50.4%	Medicare Part D revenue	2,659,802	2,148,644	511,158	23.8%
2,273,754	**1,683,860**	**589,894**	**35.0%**	**Total Operating Revenue**	**8,168,004**	**6,751,937**	**1,416,067**	**21.0%**
				Medical Expenses				
591,704	444,050	(147,654)	(33.3%)	Provider Capitation	2,196,907	1,782,455	(414,452)	(23.3%)
436,202	456,627	20,425	4.5%	Inpatient	1,776,914	1,824,011	47,097	2.6%
59,209	43,378	(15,831)	(36.5%)	Ancillary	296,959	171,989	(124,970)	(72.7%)
36,885	25,895	(10,990)	(42.4%)	Skilled Nursing Facilities	110,271	102,744	(7,527)	(7.3%)
648,531	494,348	(154,183)	(31.2%)	Prescription Drugs	2,384,004	1,949,589	(434,415)	(22.3%)
26,380	44,401	18,021	40.6%	Medical Management	145,528	176,598	31,070	17.6%
1,798,911	**1,508,699**	**(290,212)**	**(19.2%)**	**Total Medical Expenses**	**6,910,583**	**6,007,386**	**(903,197)**	**(15.0%)**
474,843	**175,161**	**299,682**	**171.1%**	**Gross Margin**	**1,257,422**	**744,551**	**512,871**	**68.9%**
				Administrative Expenses				
77,877	69,067	(8,810)	(12.8%)	Salaries, wages & employee benefits	339,573	273,668	(65,905)	(24.1%)
16,000	16,000	-	0.0%	Professional fees	64,000	64,000	-	0.0%
14,380	9,750	(4,630)	(47.5%)	Purchased services	31,711	39,000	7,289	18.7%
(12,953)	8,084	21,037	260.2%	Printing and postage	15,596	32,336	16,740	51.8%
-	537	537	100.0%	Other operating expenses	205	2,148	1,943	90.5%
39,333	35,185	(4,148)	(11.8%)	Indirect cost allocation, occupancy expens	157,330	140,740	(16,590)	(11.8%)
134,636	**138,623**	**3,987**	**2.9%**	**Total Administrative Expenses**	**608,416**	**551,892**	**(56,524)**	**(10.2%)**
340,207	**36,538**	**303,669**	**831.1%**	**Change in Net Assets**	**649,006**	**192,659**	**456,347**	**236.9%**
79.1%	***89.6%***	***10.5%***	***11.7%***	***Medical Loss Ratio***	***84.6%***	***89.0%***	***4.4%***	***4.9%***
5.9%	***8.2%***	***2.3%***	***28.1%***	***Admin Loss Ratio***	***7.4%***	***8.2%***	***0.7%***	***8.9%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
387	**416**	**(29)**	**(7.0%)**	**Member Months**	**1,530**	**1,631**	**(101)**	**-6.2%**
				Revenues				
2,415,652	2,620,034	(204,382)	(7.8%)	Medi-Cal Capitation Revenue	9,607,893	10,268,705	(660,812)	(6.4%)
601,998	611,701	(9,703)	(1.6%)	Medicare Part C Revenue	2,507,406	2,408,806	98,600	4.1%
265,855	147,856	117,999	79.8%	Medicare Part D Revenue	713,515	580,342	133,173	22.9%
3,283,505	**3,379,591**	**(96,086)**	**(2.8%)**	**Total Operating Revenue**	**12,828,814**	**13,257,853**	**(429,039)**	**(3.2%)**
				Medical Expenses				
850,620	989,489	138,869	14.0%	Medical Management	3,343,148	3,863,363	520,215	13.5%
434,517	804,292	369,775	46.0%	Facilities Claims	2,611,032	3,095,311	484,279	15.6%
739,634	680,014	(59,620)	(8.8%)	Professional Claims	2,425,835	2,596,418	170,583	6.6%
98,162	255,594	157,432	61.6%	Patient Transportation	440,845	987,155	546,310	55.3%
266,938	277,061	10,123	3.7%	Prescription Drugs	1,136,643	1,073,367	(63,276)	(5.9%)
(79)	63,927	64,006	100.1%	MLTSS	(9,952)	241,326	251,278	104.1%
4,838	18,713	13,876	74.1%	Other Expenses	19,125	72,775	53,650	73.7%
2,394,628	**3,089,090**	**694,462**	**22.5%**	**Total Medical Expenses**	**9,966,677**	**11,929,715**	**1,963,038**	**16.5%**
888,877	**290,501**	**598,376**	**206.0%**	**Gross Margin**	**2,862,137**	**1,328,138**	**1,533,999**	**115.5%**
				Administrative Expenses				
157,556	133,271	(24,285)	(18.2%)	Salaries, wages & employee benefits	568,679	493,530	(75,149)	(15.2%)
123	166	43	25.7%	Professional fees	533	664	131	19.7%
31,375	17,776	(13,599)	(76.5%)	Purchased services	39,539	71,104	31,565	44.4%
5,687	11,700	6,013	51.4%	Printing and postage	60,816	46,800	(14,016)	(29.9%)
2,018	2,070	52	2.5%	Depreciation & amortization	8,143	8,280	137	1.7%
4,560	3,597	(963)	(26.8%)	Other operating expenses	13,398	14,268	870	6.1%
4,084	4,490	406	9.0%	Indirect Cost Allocation, Occupancy Expense	13,598	17,750	4,152	23.4%
205,403	**173,070**	**(32,333)**	**(18.7%)**	**Total Administrative Expenses**	**704,706**	**652,396**	**(52,310)**	**(8.0%)**
				Operating Tax				
5,743	-	5,743	0.0%	Tax Revenue	22,705	-	22,705	0.0%
5,743	-	(5,743)	0.0%	Premium Tax Expense	22,705	-	(22,705)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
683,474	**117,431**	**566,043**	**482.0%**	**Change in Net Assets**	**2,157,431**	**675,742**	**1,481,689**	**219.3%**
72.9%	***91.4%***	***18.5%***	***20.2%***	***Medical Loss Ratio***	***77.7%***	***90.0%***	***12.3%***	***13.7%***
6.3%	***5.1%***	***(1.1%)***	***(22.2%)***	***Admin Loss Ratio***	***5.5%***	***4.9%***	***(0.6%)***	***(11.6%)***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 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				
25,296	55,000	29,704	54.0%	Purchase services	165,176	220,000	54,824	24.9%
170,912	177,250	6,338	3.6%	Depreciation & amortization	683,647	709,000	25,353	3.6%
18,423	18,500	77	0.4%	Insurance expense	73,691	74,000	309	0.4%
109,260	114,917	5,657	4.9%	Repair and maintenance	409,814	459,667	49,853	10.8%
41,875	41,250	(625)	(1.5%)	Other Operating Expense	244,394	165,000	(79,394)	(48.1%)
(365,766)	(406,917)	(41,151)	(10.1%)	Indirect allocation, Occupancy	(1,576,722)	(1,627,667)	(50,945)	(3.1%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – OCTOBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.3 million, favorable to budget $0.3 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.7 million, favorable to budget $0.6 million

CalOptima
Balance Sheet
October 31, 2020

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
	Operating Cash	$255,029,409		Accounts Payable	$57,852,845
	Investments	948,375,523		Medical Claims liability	921,395,163
	Capitation receivable	337,770,621		Accrued Payroll Liabilities	13,959,020
	Receivables - Other	50,004,412		Deferred Revenue	62,646,477
	Prepaid expenses	5,711,104		Deferred Lease Obligations	149,857
				Capitation and Withholds	160,528,945
	Total Current Assets	**1,596,891,068**		**Total Current Liabilities**	**1,216,532,307**
Capital Assets					
	Furniture & Equipment	39,890,502			
	Building/Leasehold Improvements	11,370,638			
	505 City Parkway West	51,620,226			
		102,881,366			
	Less: accumulated depreciation	(55,333,068)			
	Capital assets, net	47,548,298	Other (than pensions) post		
				employment benefits liability	25,993,822
Other Assets			Net Pension Liabilities		27,047,085
	Restricted Deposit & Other	300,000	Bldg 505 Development Rights		-
	Homeless Health Reserve	57,198,913			
	Board-designated assets:			**TOTAL LIABILITIES**	**1,269,573,214**
	Cash and Cash Equivalents	1,329,487			
	Long-term Investments	585,820,736	Deferred Inflows		
	Total Board-designated Assets	587,150,223		Excess Earnings	506,547
				OPEB 75 Difference in Experience	804,000
				Change in Assumptions	3,728,725
	Total Other Assets	644,649,136		OPEB Changes in Assumptions	1,638,000
			Net Position		
TOTAL ASSETS		**2,289,088,502**		TNE	102,841,024
				Funds in Excess of TNE	921,658,063
Deferred Outflows			**TOTAL NET POSITION**		1,024,499,087
	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	**2,300,749,572**		**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,300,749,572**

CalOptima
Board Designated Reserve and TNE Analysis
as of October 31, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,686,805				
	Tier 1 - MetLife	159,452,401				
	Tier 1 - Wells Capital	159,798,341				
Board-designated Reserve		479,937,547	319,251,517	500,148,320	160,686,030	(20,210,773)
TNE Requirement	Tier 2 - MetLife	107,212,676	102,841,024	102,841,024	4,371,652	4,371,652
	Consolidated:	**587,150,223**	**422,092,541**	**602,989,344**	**165,057,683**	**(15,839,121)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
October 31, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(2,014,967)	(632,210)
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	448,329	1,843,745
Changes in assets and liabilities:		
Prepaid expenses and other	474,419	988,105
Catastrophic reserves		
Capitation receivable	(12,609,867)	58,594,992
Medical claims liability	15,708,169	4,243,143
Deferred revenue	40,762,958	39,222,781
Payable to health networks	8,743,258	17,547,917
Accounts payable	(20,707,939)	(16,803,601)
Accrued payroll	(2,909,041)	431,176
Other accrued liabilities	(2,766)	(11,000)
Net cash provided by/(used in) operating activities	27,892,553	105,425,047
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	(57,209,964)	(224,189,210)
Change in Property and Equipment	(469,554)	(2,737,472)
Change in Board designated reserves	76,094	(2,266,330)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(57,603,424)	(229,193,013)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(29,710,870)	(123,767,966)
CASH AND CASH EQUIVALENTS, beginning of period	$284,740,279	378,797,374
CASH AND CASH EQUIVALENTS, end of period	**255,029,409**	**255,029,409**

BALANCE SHEET – OCTOBER MONTH:

ASSETS of $2.3 billion increased $39.6 million from September or 1.8%

- Investments increased $57.2 million due to the timing of cash receipts and month-end requirements for operating cash
- Capitation Receivables increased $11.7 million due to timing of cash receipts
- Operating Cash decreased $29.7 million due to the timing of cash receipts and disbursements

LIABILITIES of $1.3 billion increased $41.6 million from September or 3.4%

- Deferred Revenue increased $40.8 million due to timing of capitation payments from Centers for Medicare & Medicaid Services (CMS)
- Claims Liabilities increased $15.7 million due to timing of claim payment and changes in Incurred But Not Reported (IBNR)
- Capitation and Withholds increased $8.7 million due to timing of capitation payments
- Accounts Payable decreased $20.7 million due to payment of Managed Care Organization (MCO) tax

NET ASSETS of $1.0 billion, decreased $2.0 million from September or 0.2%

Homeless Health Initiative and Allocated Funds
as of October 31, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	$11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
CalOptima Homeless Response Team	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Days & Quality Incentive (QI) Program - Homeless Clinic Access Program (HCAP)	1,231,087	
FQHC (Community Health Center) Expansion and HHI Support	570,000	
HCAP Expansion for 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 for October 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	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
October	Medi-Cal	Maintenance HW/SW - UPS Maintenance	Maintenance HW/SW - Desktop - Adobe Acrobat	$35,000	To repurpose funds from UPS Maintenance to fund shortages in Desktop - Adobe Acrobat	2021
October	Medi-Cal	Maintenance HW/SW - Microsoft True-Up	Maintenance HW/SW - Desktop - Microsoft Enterprise License Agreement	$91,000	To repurpose funds from Microsoft License True-Up to fund shortages in the new 3-year Microsoft Enterprise License Agreement	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
December 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

- 2021 CMS Readiness Checklist (applicable to OneCare and OneCare Connect):

  On October 2, 2020, the Centers for Medicare & Medicaid Services (CMS) released the 2021 Readiness Checklist for Medicare Advantage Organizations (MAOs) and Medicare-Medicaid Plans (MMPs). Plans are expected to fulfill key operational requirements summarized in the Readiness Checklist for the 2021 benefit year. CalOptima's Regulatory Affairs & Compliance (RAC) department is leading efforts to ensure compliance with requirements set forth in the 2021 Readiness Checklist for impacted operational areas.

- 2021 Timeliness Monitoring Project (TMP):

  On September 18, 2020, CMS announced it will conduct the industry wide Timeliness Monitoring Project (TMP) starting in January 2021. CMS will collect data for organization determinations, and appeals and grievances (ODAG) to assess timeliness in processing Medicare Advantage (Part C) reconsiderations, as well as compliance with forwarding cases to the independent review entity (IRE). Beginning with the 2021 TMP, CMS will no longer collect the Part D coverage determinations, and appeals and grievances (CDAG) audit universes used to evaluate these measures.

  The review period requested for CalOptima will be January to March 2020. Findings may result in compliance actions, if necessary, and may have implications for the Star Ratings. At this time, CalOptima is pending the CMS engagement notice, expected to be released in January 2021.

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- Compliance Program Effectiveness (CPE) Audit (applicable to OneCare and OneCare Connect):

  CalOptima is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program, as outlined in the CMS Medicare Parts C and D Program Audit Protocols.

  On August 17, 2020, CalOptima received an audit engagement letter from the independent auditor. The audit was held virtually from October 12 – 19, 2020. On November 13, 2020, CalOptima received the final audit report, which cited one (1) finding related to timely completion of audit activities and corrective action plans. The auditor also recognized CalOptima for having implemented four (4) best practices related to the organization and comprehensiveness of CalOptima's compliance program, its communication channels, oversight activities for call center monitoring, and the comprehensiveness of its FWA investigation process and related communications.

2. PACE

- 2019 CMS Financial Audit:

  On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CalOptima was notified that the Certified Public Accountant (CPA) firm, Myers & Stauffer, will be leading this audit. Myers & Stauffer will audit and inspect any books and records of the CalOptima that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract.

  On October 21, 2020, Myers & Stauffer held an entrance conference to discuss the different sections of the audit engagement, initial priorities, and timing of the remainder of the examination. CalOptima has completed the 30-day document request and 60-day document request by each of the respective deadlines.

3. Medi-Cal

- 2021 DHCS Medical Audit (Postponed):

  Due to the ongoing public health emergency, the Department of Health Care Services (DHCS) will not be conducting its annual medical audit of CalOptima's Medi-Cal program in 2021. Instead, the DHCS will resume its audit cycle for CalOptima in 2022 and will utilize a two-year lookback period instead of the customary one-year lookback period. In

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2022, the audit scope will include the Medi-Cal Seniors and Persons with Disabilities (SPD) and the Non-SPD population.

- 2020 DHCS Medical Audit:

  The DHCS' onsite audit of CalOptima took place from January 27, 2020 to February 7, 2020. The audit covered the review period of February 1, 2019 to January 31, 2020 and pertained to CalOptima's Medi-Cal program as well as elements of its OneCare Connect Medicaid-based services. DHCS reviewed an array of documents and data and conducted interviews with CalOptima staff as well as with a DHCS-selected delegate, Monarch HealthCare.

  On August 11, 2020, the DHCS provided CalOptima with a final audit report and a formal request for a corrective action plan (CAP). The report identified seven (7) Medi-Cal findings in the audit areas of Access and Availability of Care and Member's Rights. CalOptima did not receive any findings for State Supported Services or the Cal MediConnect program. CalOptima submitted a timely CAP to the DHCS by the deadline of September 11, 2020.

  On October 27, 2020, CalOptima provided two (2) revisions to the original CAP submitted on September 11, 2020. The DHCS continues to review the CAP and engage CalOptima in ongoing dialogue, offering feedback and support. CalOptima will continue to provide monthly status updates to the DHCS on its progress implementing the CAP. The next monthly update is due to DHCS no later than November 11, 2020.

- Rate Development Template (RDT) Audit:

  On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit which focuses on the accuracy and completeness of calendar year 2017 Medi-Cal RDT encounter and financial data submitted to the DHCS as part of the rate development process for 2019-20.

  On August 7, 2019, Mercer auditors were onsite to interview key staff. On October 11, 2020, CalOptima received Mercer's final audit report. Based on the summary of findings in the report, Mercer identified small but acceptable variances, and provided recommendations to increase the validity of CalOptima RDT medical expense reporting. Mercer noted the results of the audit for administrative expenditures are determined to be immaterial and do not warrant corrective action.

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of October 2020.

C. Updates on Internal and Health Network Monitoring and Audits

1. Monitoring Dashboard: Medi-Cal Grievance & Appeals Resolution Services (GARS) [a\]

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- As part of the monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of June - September 2020 for Medi-Cal GARS. CalOptima's GARS department did not meet resolution timeliness requirements for four (4) consecutive months for Medi-Cal expedited appeals.

Month	Compliance Goal	Expedited Appeals Resolved within ≤ 72 Hours of Receipt
June 2020	98%	88%
July 2020	98%	88%
August 2020	98%	88%
September 2020	98%	88%

  - ➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during its oversight of the dashboard measure for Medi-Cal 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 processing of expedited appeals.

2. Internal Monitoring: Medi-Cal, OneCare and OneCare Connect [a\]

- Exclusion Monitoring: Contracting

Month	General Services Administration's (GSA) System for Award Management (SAM)	Medi-Cal Suspended and Ineligible (S&I)	OIG Exclusions Database (OIG LEIE Database)	CMS Preclusion List
June 2020	100%	100%	100%	100%
July 2020	75%	75%	75%	75%
August 2020	100%	100%	100%	100%

  - ➢ CalOptima's Contracting department conducts exclusion monitoring for CalOptima's health networks, medical group practitioners, and non-medical providers. For the June 2020 file review of the exclusion monitoring process, CalOptima's Contracting department received a compliance score of 100% based on a focused review of two (2) exclusion monitoring files selected for review.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- For the July 2020 file review, CalOptima's Contracting department received a compliance score of 75% based on a focused review of four (4) exclusion monitoring files selected for review. The lower compliance scores were due to data integrity issues.

- For the August 2020, CalOptima's Contracting department received a compliance score of 100% based on a focused review of three (3) exclusion monitoring files selected for review.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during its focused review of the exclusion monitoring process. The A&O department continues to work with the Contracting department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely exclusion monitoring.

- Exclusion Monitoring: Human Resources

Month	General Services Administration's (GSA) System for Award Management (SAM)	Medi-Cal Suspended and Ineligible (S&I)	OIG Exclusions Database (OIG LEIE Database)	CMS Preclusion List
June 2020	100%	96.67%	100%	100%
July 2020	100%	100%	100%	100%
August 2020	100%	100%	100%	100%

- CalOptima's Human Resources department conducts initial and ongoing exclusion monitoring for CalOptima's employees and its Board of Directors.

- Based on a focused review of thirty (30) exclusion monitoring files for each of the months of June - August 2020, CalOptima's Human Resources department received a compliance score of 96.67% for its monitoring of the Medi-Cal S&I list due to one (1) file missing information.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) to the Human Resources department for the deficiency identified. The A&O department continues to work with the Human Resources department to remediate the deficiency by identifying accurate root causes and implementing quality controls to ensure accurate and timely exclusion and preclusion monitoring.

5 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Exclusion Monitoring: Quality Improvement

Month	General Services Administration's (GSA) System for Award Management (SAM)	Medi-Cal Suspended and Ineligible (S&I)	OIG Exclusions Database (OIG LEIE Database)	CMS Preclusion List
June 2020	100%	100%	100%	100%
July 2020	100%	100%	100%	100%
August 2020	100%	100%	100%	100%

  - CalOptima's Quality Improvement department conducts exclusion monitoring for CalOptima's medical providers, practitioners, and health delivery organizations.

  - Based on a focused review of thirty (30) exclusion monitoring files for each of the months of June - August 2020, CalOptima's Quality Improvement department received a compliance score of 100%.

- Exclusion Monitoring: Regulatory Affairs & Compliance

Month	General Services Administration's (GSA) System for Award Management (SAM)	Medi-Cal Suspended and Ineligible (S&I)	OIG Exclusions Database (OIG LEIE Database)	CMS Preclusion List
June 2020	100%	100%	100%	100%
July 2020	100%	100%	100%	100%
August 2020	100%	100%	100%	100%

  - CalOptima's Regulatory Affairs & Compliance department conducts monthly exclusion monitoring for CalOptima's first-tier, downstream, and related entities (FDRs), and vendors.

  - Based on a focused review of thirty (30) exclusion monitoring files for each of the months of June - August 2020, CalOptima's Regulatory Affairs & Compliance department received a compliance score of 100%.

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.

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- Exclusion Monitoring: Vendor Management

Month	General Services Administration's (GSA) System for Award Management (SAM)	Medi-Cal Suspended and Ineligible (S&I)	OIG Exclusions Database (OIG LEIE Database)	CMS Preclusion List
June 2020	100%	100%	100%	100%
July 2020	100%	100%	100%	100%
August 2020	100%	100%	100%	100%

- CalOptima's Vendor Management department conducts initial exclusion monitoring for CalOptima's first-tier, downstream, and related entities (FDRs), and vendors.

- Based on a focused review of eight (8) exclusion monitoring files for the months of June - August 2020, CalOptima's Vendor Management department received a compliance score of 100%.

3. 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
July 2020	100%	100%	100%	100%	100%
August 2020	100%	100%	100%	100%	100%

- For the July 2020 file review of Medi-Cal standard appeals, CalOptima's GARS department received a compliance score of 100% based on a focused review of twelve (12) standard appeals selected for review.

- For the August 2020 file review of Medi-Cal standard appeals, CalOptima's GARS department received a compliance score of 100% based on a focused review of ten (10) standard appeals selected for review.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal GARS: Expedited 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
July 2020	100%	100%	100%	87.5%	87.5%
August 2020	100%	N/A	100%	100%	90%

- Based on a focused review of eight (8) Medi-Cal expedited appeals for July 2020, the lower compliance score of 87.5% for member notice content was due to one (1) file not containing criteria name/title in the resolution letter utilized for review.

- Based on a focused review of eight (8) Medi-Cal expedited appeals for July 2020, the lower compliance score of 87.5% for resolution of expedited appeals resolved within 72 hours of receipt was due to one (1) file not meeting the timeframe for processing an expedited appeal.

- Based on a focused review of ten (10) Medi-Cal expedited appeals files for August 2020, the lower compliance score of 90% for the resolution of expedited appeals resolved within 72 hours of receipt was due to one (1) file not meeting the timeframe for processing an expedited appeal.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Medi-Cal 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 processing of expedited appeals.

- 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
July 2020	100%	100%	100%	70%	100%
August 2020	100%	100%	100%	77.78%	100%

- Based on a focused review of ten (10) Medi-Cal standard grievances for July 2020, the lower compliance score of 70% for member notice content was due to three (3) files not

8 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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meeting the required sixth (6th) grade reading level in the resolution letters. One (1) of the files also failed due to incomplete resolution.

- Based on a focused review of nine (9) Medi-Cal standard grievances for August 2020, the lower compliance score of 77.78% for the member notice content was due to two (2) files not meeting the required sixth (6th) grade reading level in the resolution letters.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Medi-Cal's 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 processing of standard grievances.

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
July 2020	100%	100%	100%	50%	90%
August 2020	100%	100%	90.91%	81.82%	100%

- Based on a focused review of ten (10) Medi-Cal expedited grievances for July 2020, the lower compliance score of 50% for member notice content is due to five (5) files failing due to the resolution letters not being issued at the sixth (6th) grade reading level. One (1) of the files also failed due to incomplete resolution.

- Based on a focused review of ten (10) Medi-Cal expedited grievances for July 2020, the lower compliance score of 90% for expedited grievances resolved within ≤ 72 hours of receipt was due to one (1) file not being resolved within the required timeframe.

- Based on a focused review of eleven (11) Medi-Cal expedited grievances for August 2020, the lower compliance score of 90.91% for language preference was due to one (1) resolution letter not being in the member's preferred language.

- Based on a focused review of eleven (11) Medi-Cal expedited grievances for August 2020, the lower compliance score of 81.82% for the member notice content was due to two (2) files failing due to the following reasons:
  - One (1) file failed due to the resolution letter not being issued at the sixth (6th) grade reading level.
  - One (1) file failed due to incomplete resolution.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of Medi-Cal

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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expedited 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 processing of expedited grievances.

- Medi-Cal Utilization Management: Standard Prior Authorizations

Month(s)	Universe Integrity	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Members Preferred Language	Accuracy of Member Notice Content	Universe Validation
July 2020	90%	100%	100%	100%	100%	100%	100%	100%	100%
August 2020	100%	90%	70%	100%	70%	100%	100%	90%	100%

- Based on a focused review of ten (10) Medi-Cal prior authorizations for July 2020, the lower compliance score of 90% was due to a universe integrity issue.

- Based on a focused review of ten (10) Medi-Cal prior authorizations for August 2020, the lower compliance score of 90% for file classification was due to a misclassified file in the universe.

- Based on a focused review of ten (10) Medi-Cal prior authorizations for August 2020, the lower compliance score of 70% was for untimely resolution of prior authorizations.

- Based on a focused review of ten (10) Medi-Cal prior authorizations for August 2020, the lower compliance score of 70% for clinical decision making review was due to not following the appropriate ordering for clinical decision making.

- Based on a focused review of ten (10) Medi-Cal prior authorizations for August 2020, the lower compliance score of 90% for accuracy of member notice content was due to a denial letter not meeting the sixth (6^{th}) 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 Medi-Cal prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard prior authorizations.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal Utilization Management: Urgent Prior Authorizations

Month(s)	Universe Integrity	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Members Preferred Language	Accuracy of Member Notice Content	Universe Validation
July 2020	100%	100%	100%	100%	100%	100%	100%	100%	100%
August 2020	100%	100%	100%	100%	100%	100%	100%	80%	100%

- For the July 2020 file review of Medi-Cal urgent prior authorizations, CalOptima's Utilization Management department received a compliance score of 100% for a focused review of six (6) urgent prior authorizations.

- Based on a focused review of ten (10) Medi-Cal urgent prior authorization for August 2020, the lower compliance score of 80% for accuracy of member notice content was due to notices not written in lay language.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of urgent Medi-Cal prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of urgent prior authorizations.

4. Internal Monitoring: OneCare [a\]

- 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
July 2020	N/A	100%	100%	N/A	100%	100%
August 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- For the July 2020 file review of OneCare standard appeals, CalOptima's GARS department received a compliance score of 100% based on a focused review of one (1) standard appeal file selected for review.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare GARS: Standard Grievances

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
July 2020	100%	100%	100%	N/A	25%	100%
August 2020	100%	100%	100%	100%	57.14%	100%

- Based on a focused review of four (4) OneCare standard grievances for July 2020, the lower compliance score of 25% for member notice content was due to three (3) resolution letters exceeding the sixth (6th) grade reading level. One (1) of the files also failed due to incomplete resolution.

- Based on a focused review of seven (7) OneCare standard grievances for August 2020, the lower compliance score of 57.14% for member notice content was due to three (3) resolution letters exceeding the sixth (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 processing of standard grievances.

- OneCare Utilization Management: Standard Pre-Service Organization Determinations

Month(s)	Universe Integrity	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Members Preferred Language	Accuracy of Member Notice Content	Universe Validation
July 2020	100%	100%	100%	100%	75%	100%	100%	100%	100%
August 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- Based on a focused review of four (4) OneCare standard pre-service organization determinations for July 2020, the lower compliance score of 75% for clinical decision making review was due to incorrect medical criteria applied.

- 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

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OneCare pre-service organization determinations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of pre-service organization determinations.

5. Internal Monitoring: OneCare Connect [a\]

- 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
July 2020	100%	100%	100%	100%	100%	100%
August 2020	100%	100%	100%	100%	70%	100%

➢ Based on a focused review of ten (10) OneCare Connect standard appeals for August 2020, the lower compliance score of 70% for member notice content was due to three (3) resolution letters exceeding the sixth (6^{th}) 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 processing of standard appeals.

- OneCare Connect GARS: Expedited 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
July 2020	100%	100%	100%	100%	100%	100%
August 2020	Nothing To Report	Nothing To Report	Nothing To Report	Nothing To Report	Nothing To Report	Nothing To Report

➢ For the July 2020 file review of OneCare Connect expedited appeals, CalOptima's GARS department received a compliance score of 100% based on a focused review of one (1) expedited appeal file selected for review.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Connect 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
July 2020	100%	100%	100%	100%	46.67%	100%
August 2020	100%	100%	100%	100%	86.67%	100%

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for July 2020, the lower compliance score of 46.67% for member notice content was due to the following:
  - Seven (7) files failed due to the resolution letters exceeding the sixth (6^{th}) grade reading level.
  - Two (2) files failed due to incomplete resolution letters.

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for August 2020 file, the lower compliance score of 86.67% for member notice content was due to two (2) files containing an inaccurate grievance filing date on the resolution letters.

- 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 processing of standard grievances.

- OneCare Connect Utilization Management: Standard Prior Authorizations

Month(s)	Universe Integrity	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content	Universe Validation
July 2020	100%	100%	100%	90%	80%	100%	100%	100%	100%
August 2020	100%	100%	100%	100%	80%	100%	90%	90%	100%

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for July 2020, the lower compliance score of 90% was due to missing documentation for a provider notification.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for July 2020, the lower compliance score of 80% for clinical decision making review was due to not following the appropriate ordering for clinical decision making.

- Based on a focused review of ten (10) OneCare Connect prior authorizations for August 2020, the lower compliance score of 80% for clinical decision making review was due to applying incorrect medical criteria.

- Based on a focused review of ten (10) OneCare Connect prior authorizations for August 2020, the lower compliance score of 90% for accuracy of member notice content was due to one (1) notice not being written in lay language.

- 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 prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard prior authorizations.

- OneCare Connect Utilization Management: Expedited Service Authorizations

Month(s)	Universe Integrity	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Members Preferred Language	Accuracy of Member Notice Content	Universe Validation
July 2020	100%	100%	100%	80%	80%	100%	100%	100%	100%
August 2020	100%	100%	100%	80%	90%	100%	80%	90%	100%

- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for July 2020, CalOptima's Utilization Management department received a compliance score of 80% due to untimely member notifications.

- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for July 2020, the lower compliance score of 80% for clinical decision making review was due to not following the appropriate ordering for clinical decision making.

- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for August 2020, CalOptima's Utilization Management department received a compliance score of 80% due to untimely member notifications.

- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for August 2020, the lower compliance score of 90% for clinical decision making review was due to not following the appropriate ordering for clinical decision making.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for August 2020, CalOptima's Utilization Management department received a compliance score of 80% due to the member notice not being written in the member's preferred language.

- Based on a focused review of ten (10) OneCare Connect expedited prior authorizations for August 2020, the lower compliance score of 90% for accuracy of member notice content was due to one (1) notice not being written in lay language.

- 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 OneCare Connect prior authorizations. The A&O department continues to work with the Utilization Management department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited prior authorizations.

6. Internal Audits: OneCare and OneCare Connect Medication Therapy Management (MTM) Program

   - During the third quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's OneCare and OneCare Connect Medication Therapy Management Program to ensure compliance with universe, timeliness, and clinical decision making requirements for the review period of January 2020- June 2020. No findings were identified during the audit.

Measures	Files Reviewed	Compliant Files	Non- Compliant Files	Compliance Score
Medication Therapy Management (MTM) Enrollment				
Universe submission timeliness	1	1	0	100%
Universe accuracy	5	5	0	100%
Comprehensive Medication Reviews (CMRs) and Targeted Medication Reviews (TMRs)				
Annual CMR offered?	5	5	0	100%
For newly targeted beneficiaries, CMR offered within 60 days of enrollment?	5	5	0	100%
Cognitively impaired members were appropriately outreached to via an authorized representative (AOR) to offer a CMR?	5	5	0	100%
Annual CMR performed in accordance with CMS' professional service definition?	5	5	0	100%
Written summary of CMR provided to member/AOR in the standardized format, if applicable?	5	5	0	100%

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CMR services were provided consistent with the approved program description, if applicable?	5	5	0	100%
TMRs performed at least quarterly?	5	5	0	100%
TMR services were provided consistent with the approved program description?	5	5	0	100%
TMR beneficiary/provider interventions are implemented consistent with the approved program description?	5	5	0	100%

7. 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
June 2020	90%	91%	95%	91%	85%	87%	94%	79%	88%	95%	96%	75%	93%
July 2020	82%	93%	98%	91%	94%	91%	94%	81%	96%	97%	100%	98%	96%
August 2020	77%	100%	100%	91%	99%	96%	96%	96%	96%	99%	67%	89%	100%

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for timeliness. Six (6) of the eleven (11) files received from the five (5) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for decision (Urgent – 72 hours)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (24 hours)
  - Failure to meet timeframe for extended decision

- Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making. Only one (1) file was submitted by the health network, and the one (1) file was deficient. The deficiency was for failure to cite criteria for decision.

- Based on the overall universe of Medi-Cal authorizations for July 2020, CalOptima's health networks received an aggregate compliance score of 99.91% for timely processing of routine authorization requests and a compliance score of 96.88% for timely processing of expedited authorization requests.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

8. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
June 2020	95%	100%	91%	99%	93%	100%	82%	98%
July 2020	87%	100%	91%	100%	93%	98%	100%	100%
August 2020	100%	NTR	89%	100%	90%	97%	100%	97%

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness. Only one (1) of the ten (10) files received from the health network was deficient. The deficiency for the lower score for timeliness was for failure to meet timeframe for provider notification.

- Based on a focused review of select files, five (5) health networks drove the lower compliance letter score. Eight (8) out of the eighteen (18) files received from the five (5) health networks were deficient. Deficiencies for the lower letter scores included the following:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to use CMS-approved template

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for July 2020 CalOptima's health networks received an overall compliance score of 98.67% for timely processing of standard Part C authorization requests and 73.84% for timely processing of expedited Part C authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and

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implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2020	92%	97%	95%	97%
July 2020	100%	100%	99%	97%
August 2020	88%	88%	86%	86%

  - Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 100% in July 2020 to 88% in August 2020 due to untimely processing of a claim. The lower score was driven by one (1) health network with one (1) file submitted and marked deficient for timeliness.

  - Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 100% in July 2020 to 88% in August 2020 due to missing documents that are required for processing accurate payment on a claim. The lower score was driven by one (1) health network with one (1) file submitted and marked deficient for accuracy.

  - Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 99% in July 2020 to 86% in August 2020 due to untimely processing of a claim. The lower score was driven by one (1) health network with two (2) files submitted and one (1) file marked deficient for timeliness.

  - Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 97% in July 2020 to 86% in August 2020 due to missing documents that are required for processing accurate payment on a claim. The lower score was driven by one (1) health network with two (2) files submitted and one (1) file marked deficient for accuracy.

  - Based on the overall universe of OneCare claims for CalOptima's health networks for July 2020, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
    - 94.40% for non-contracted clean claims paid or denied within 30 calendar days of receipt
    - 98.98% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

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- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

9. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
June 2020	96%	100%	94%	94%	93%	99%	94%	99%	95%	90%	96%
July 2020	99%	87%	89%	94%	94%	98%	86%	94%	86%	92%	100%
August 2020	100%	100%	92%	90%	87%	100%	93%	94%	80%	93%	100%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness. Three (3) out of the four (4) files received from the two (2) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for decision (Routine – 5 business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification

- Based on a focused review of select files, six (6) health networks drove the lower compliance letter score. Six (6) out of the twelve (12) files received from the six (6) health networks were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to provide letter in member preferred language
  - Failure to provide letter with description of services in lay language

- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for July 2020, CalOptima's health networks received an overall compliance score of 99.99% for timely processing of routine authorization requests and 99.84% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health

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network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2020	91%	86%	92%	97%
July 2020	95%	95%	100%	99%
August 2020	85%	85%	89%	89%

- Based on a focused review of select files, the compliance score for paid claims timeliness decreased from 95% in July 2020 to 85% in August 2020 due to untimely processing of multiple claims. The lower score was driven by two (2) health networks with four (4) files submitted and all files marked deficient for timeliness.

- Based on a focused review of select files, the compliance score for paid claims accuracy decreased from 95% in July 2020 to 85% in August 2020 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by two (2) health networks with three (3) out of four (4) files submitted marked deficient for accuracy.

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 100% in July 2020 to 89% in August 2020 due to untimely processing of a claim. The lower score was driven by one (1) health network with one (1) out of two (2) files submitted marked deficient for timeliness.

- Based on a focused review of select files, the compliance score for denied claims accuracy decreased from 99% in July 2020 to 89% in August 2020 due to missing documents that are required for processing accurate payment on claims. The lower score was driven by one (1) health network with two (2) files submitted and marked deficient for accuracy.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for July 2020, CalOptima's health networks received the following overall compliance scores:
  - 99.17% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- 99.85% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
- 99.94% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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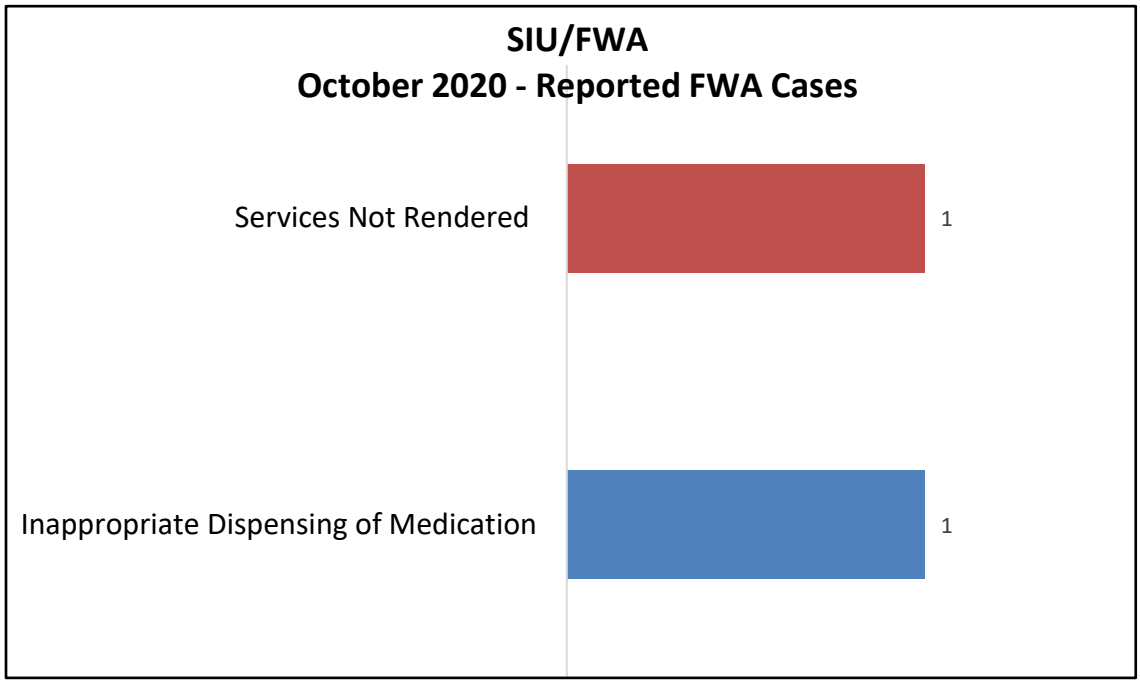
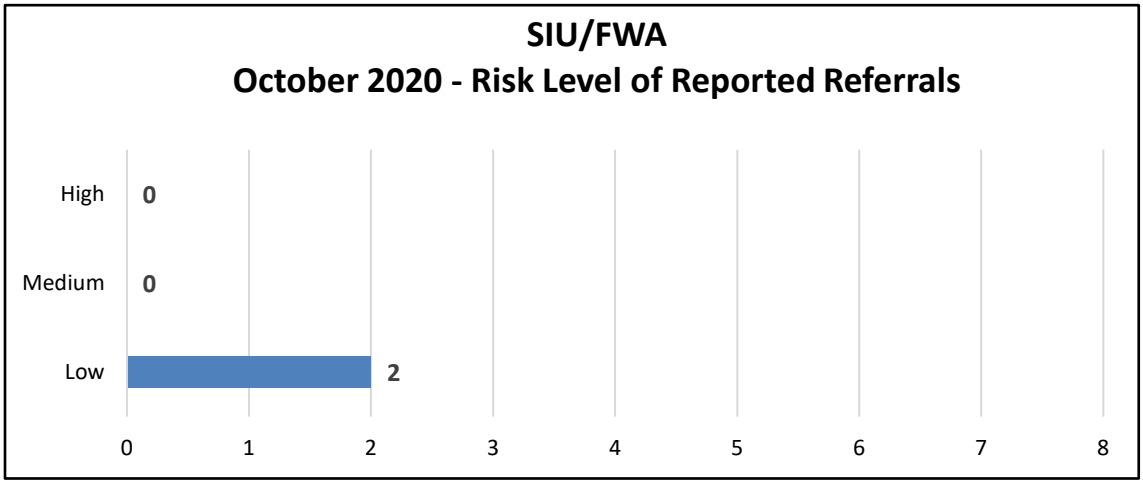
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in October 2020)





Total Number of Referrals Reported to DHCS (State)	2
Total Number of Referrals Reported to I-MEDIC (CMS)	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.

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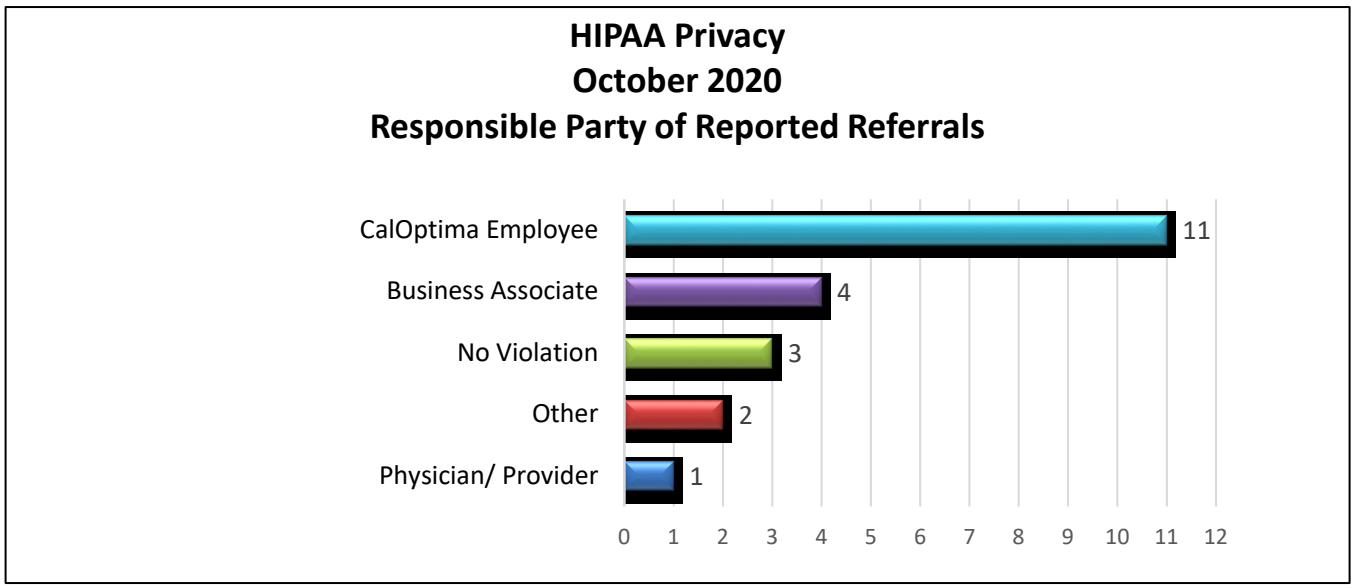
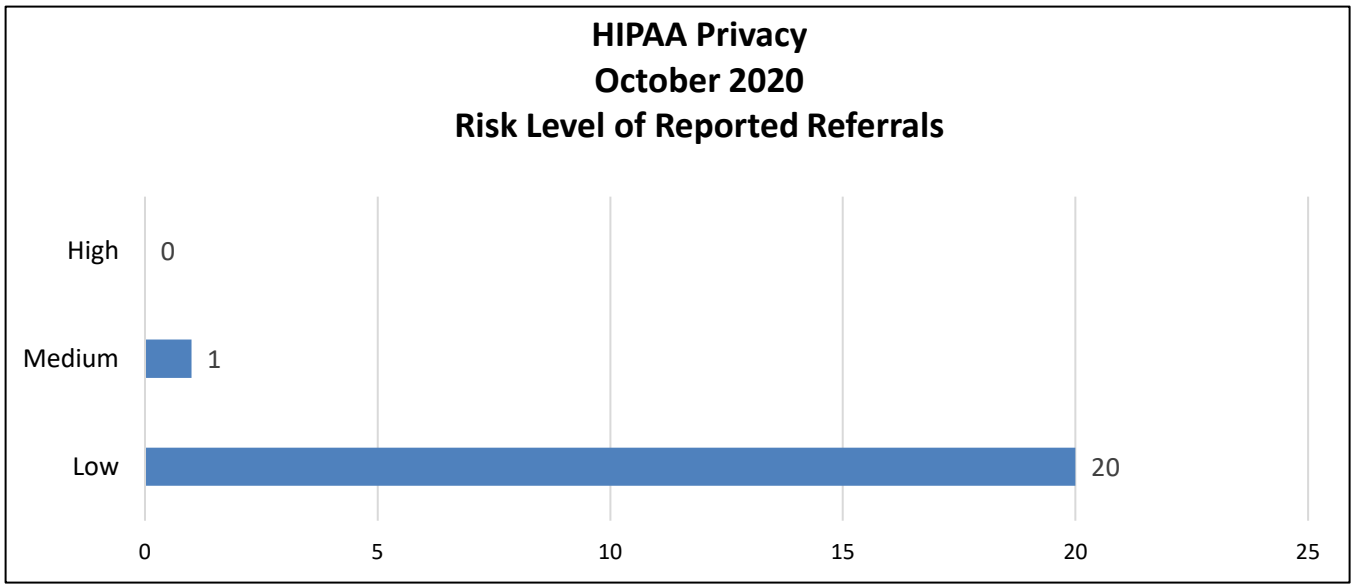
E. Privacy Update: (October 2020)





Total Number of Referrals Reported to DHCS (State)	20
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	1
Total Number of Referrals Reported	**20**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

November 16, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: November Board of Directors Report

All eyes were on the elections this month, which yielded a victory for presidential candidate Joe Biden even as the status quo is expected to prevail in Congress. Meanwhile, appropriations work and COVID-19 relief will dominate Congress' lame duck agenda, though a deal on the latter has so far proved elusive. This report covers developments through November 16.

2020 Election Results

Former Vice President Joe Biden (D) defeated President Donald Trump (R) in the 2020 presidential election, the first time since 1992 that an incumbent president has failed to be reelected for a second term. The race saw record turnout, with each candidate receiving more than 70 million votes. With about 97 percent of votes counted nationwide, Biden currently stands at 290 electoral votes and President Trump at 232. The race remains too close to call in Georgia, where a hand recount is underway. As of November 16, President Trump has refused to concede the election, disputing the results and claiming that millions of votes were illegally cast. He has filed a number of lawsuits disputing election results in multiple states, but these challenges are making little headway in courts.

Senate Republicans performed better than expected on November 3, fending off a number of Democratic challengers and defeating Sen. Doug Jones (D) in Alabama. Democrats flipped seats in Colorado and Arizona. Currently, Republicans have 50 seats and Democrats have 48. Control of the Senate will come down to two Georgia races that are headed to a run-off in January. Republican incumbents Kelly Loeffler and David Perdue will be defending their seats against Democratic challengers in races that could set fundraising records. If Republicans win one or both of the Georgia races, the GOP will maintain control of the Senate. Democrats need both seats to have a majority (with Vice President Kamala Harris acting as the tie-breaker).

Democrats will maintain control of the House in 2021, albeit with a smaller majority after Republicans made unexpected gains on Election Day. Currently, Democrats have won 219 seats and Republicans have won 203. Thirteen races have yet to be called. Notably, women and minority candidates drove many of the GOP's gains in the House. At least 35 Republican women are expected to serve in the 117th Congress. Among the new Republican women the House will welcome are Michelle Steel and Young Kim for the Orange County delegation.

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Lame Duck Agenda

As the 116th Congress concludes its second session, near-term action is expected on several "must-pass" measures during the lame duck period. In order to avoid a government shutdown, Congress will need to pass a spending bill before the current Continuing Resolution (CR) expires on December 11. The House has passed 10 of the 12 Fiscal Year (FY) 2021 appropriations bills; the Senate Appropriations Committee released its text and committee reports for the 12 spending bills on November 9. Markups of the Senate bills are unlikely given the tight timeframe.

Senate Majority Leader Mitch McConnell (R-KY) and House Speaker Nancy Pelosi (D-CA) both have predicted that an omnibus spending package will be used to wrap up FY 2021 appropriations, rather than a short-term CR into early 2021. House and Senate appropriators also may pursue a dual package – a so-called "CRomnibus" – that would include an assortment of agreed-upon FY 2021 appropriations bills combined with a CR to fund the remainder of the appropriations bills at current levels through September 30, 2021.

Health care extenders also were included in the latest CR and are now set to expire on December 11. Authorizers are invested in extending the expiring provisions on a longer-term basis, but whether this is feasible in the context of the funding vehicle likely will depend on whether appropriators are able to reach broader agreement on 2021 funding or pass a clean CR extending current funding levels.

An agreement on a targeted legislative package to address the COVID-19 pandemic is possible in the lame duck. However, a more comprehensive bill appears unlikely given current divisions. Senate Republicans are arguing that Democrats' losses in the House signal support for a smaller package with a total cost of less than $1 trillion. Speaker Pelosi, meanwhile, continues to make the case for a more far-reaching package. Prior to the election, President Trump called for spending more than the $2.4 trillion that House Democrats included in their most recent proposal. It remains unclear how the White House will negotiate now that the President has lost his reelection bid.

While the congressional calendar is subject to change depending on the status of appropriations and possible COVID-19 relief, the House is scheduled to be in session following the Thanksgiving recess from December 1-4 and December 7-10. Members-elect will participate in orientation and leadership elections will take place the week of November 16-20. The Senate will return to Washington following Thanksgiving on November 30 and are expected to stay until December 21. Senate Republicans and Democrats recently held leadership elections for the 117th Congress. Majority Leader McConnell and Minority Leader Chuck Schumer (D-NY) will remain as party leaders. The other Republican leaders will remain the same. Democrats added Sens. Cory Booker (D-NJ) and Catherine Cortez Masto (D-NV) to leadership.

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Outlook for 2021

President-elect Biden will likely take office with a divided Congress in 2021, limiting his ability to advance progressive policies. With a narrower Democratic majority in the House, a Republican Senate, and no ability to use the budget reconciliation process, he will have little immediate recourse if the Supreme Court strikes down the Affordable Care Act (ACA). Any replacement would require support from Senate Republicans, who tried several times over the past four years to repeal the law. The Biden Administration is expected to roll back the Trump Administration's Section 1332 guidance, which gave states additional flexibility to waive ACA insurance requirements. President-elect Biden is expected to deny any pending requests from states seeking permission to test work requirements in Medicaid and shift the Administration's positions in lawsuits challenging work requirements already approved in other states. In addition, the Medicaid Fiscal Accountability Regulation (MFAR) is unlikely to be resurrected under the Biden Administration.

Biden has touted his ability to work across the aisle, and he may try to strike deals with Republicans on narrow drug pricing reforms as well as surprise medical billing. Absent a willing Congress, the Biden Administration could use executive orders and demonstration authority to advance health care priorities. There are also opportunities for bipartisan cooperation on high-tech and privacy initiatives, as well as trade, supply chain, and China-related measures.

Of course, President-elect Biden's top priority next year will be COVID-19 response. His first action is expected to be a rollout of a new nationwide plan to combat the virus and support small businesses. Biden has indicated he will use the "full power" of the Defense Production Act (DPA) to facilitate domestic manufacturing of personal protective equipment (PPE). A key focus will also be distribution of a COVID-19 vaccine. The companies behind several leading candidates are expected to soon apply for emergency use authorizations. Biden has already named members of a new COVID-19 task force, to be chaired by former U.S. Surgeon General Vivek Murthy, former Food and Drug Administration (FDA) Commissioner David Kessler, and Dr. Marcella Nunez-Smith, a professor at Yale School of Medicine. Biden has not yet announced his cabinet members, but possible contenders for Health and Human Services Secretary include Dr. Murthy and New Mexico Gov. Michelle Lujan Grisham (D) .

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CalOptima Legislative Update
By Don Gilbert, Trent Smith and Bridget McGowan
November 16, 2020

2020 Election Update

California experienced what appears to be a record 82 percent voter turnout, with high early votes from Democrats and high day-of and late arriving ballots favoring Republicans, so far. This is a departure from past elections in which late arriving ballots favored Democrats in contested contests.

At this time, there are still ballots remaining to be counted, but races are now being called.

State Senate. The State Senate is currently comprised of 29 Democrats and 11 Republicans. The Democrats mounted well-funded challenges to four seats currently held by Republicans. The Republicans will lose two Orange County seats and are currently ahead in two other Southern California races.

SD 29 – Josh Newman (D) will defeat the incumbent **Senator Ling Ling Chang (R)**
SD 37 – Dave Min (D) will defeat incumbent **Senator John Moorlach (R)**
SD 23 – Rosilicie Ochoa Bogh (R) is likely to prevail over **Abigail Medina (D)**
SD21 – Incumbent **Senator Scott Wilk (R)** is holding a lead over **Kipp Mueller (D)**

State Assembly

The Assembly is currently comprised of 61 Democrats, 17 Republicans, an Independent, and a vacancy. The Assembly Democrats were defending three seats won from Republicans in 2018 and going after four seats held by Republicans. After millions of dollars spent on these contested seats, none of the seats changed parties from these targeted races.

The Democrats defended all three of their 2018 wins and failed to gain any of the four Republican seats that were targeted.

In fact, the Republicans will gain one seat as Suzette Valladares won a Democratic seat that opened when Christy Smith ran for Congress and the Democrats failed to place a candidate in the race.

When the Assembly convenes in December there will be 60 Democrats, 19 Republicans and an Independent.

Ballot Initiatives

There were a dozen ballot initiatives on the statewide ballot.

Of particular interest to many is the outcome of **Proposition 15** to increase property tax on commercial property. If passed, increased property taxes would have brought an additional $10-$12 billion in new revenue to local governments and schools. Last Tuesday night, the Associated Press called the race, with the "No" side prevailing at 51.8% of the vote.

A common theme among the ballot fights is that the side that spent the most money prevailed. That was the case with **Proposition 22** put on the ballot by Uber, Lyft and other Gig economy businesses who spent close to $225 million to pass this initiative.

Similarly, dialysis clinics outspent the healthcare unions to defeat **Proposition 23**. Realtors and firefighters raised over $45 million and are currently ahead in the effort to pass **Proposition 19**. While former Governor Brown and criminal justice reform advocates spent $22 million to defeat **Proposition 20** to increase criminal penalties for certain crimes. Finally, property owners and landlords spent $134 million to defeat **Proposition 21** which would have created a California rent control law.

Interestingly, voters appear to be rejecting two measures placed on the ballot by their elected representatives and a third measure to overturn a law previously created by the Legislature. **Proposition 16 to** overturn the ban on affirmative action programs in university admissions and government hiring and contracting is currently behind 44% to 56% and will likely fail. **Proposition 18** to allow 17-year-olds to vote in primaries will also lose. Finally, **Proposition 25** is a referendum on a law passed by the Legislature that ended cash bail.

Election Takeaways

There was not a Democratic wave in California. Despite Biden receiving 10 million votes and handily beating Trump, the President has so far received 600,000 more votes in California than he did in 2016. As a result, down ticket Democrats most certainly did not ride a pro-Biden wave, despite the two-seat pick-up in the Senate.

The 2020 outcome will now trigger a series of possible appointments of elected officials to federal offices which will cascade and reverberate down the political pipeline. If the Governor selects a statewide officer to replace Vice-President elect Harris in the Senate, then he will also get to replace that statewide officer as well. Any number of currently elected officials might leave to work in the Biden Administration which would trigger special elections to fill those positions. There will already be a special election to fill a state Senate seat that will open when Senator Holly Mitchell becomes a County Supervisor in Los Angeles. It is possible the makeup of the Legislature will be unsettled until the 2022 election cycle when new political boundaries will further shakeup the status quo.

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2019–20 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 266 McCollum	**Paycheck Protection Program and Health Care Enhancement Act:** Authorizes $483 billion to replenish segments of the CARES Act, expand coronavirus testing, and provide more support to hospitals and providers during this pandemic. Of the $483 billion, this bill includes: ■ $310 billion in funding for the Small Business Administration's PPP; ■ $10 billion for Economic Injury Disaster Loans; ■ $75 billion for the provider relief fund, managed by the Department of Health and Human Services, to cover treatment for COVID-19 patients and lost revenue from canceled elective procedures; and ■ $25 billion to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests.	**04/24/2020** Signed into law **04/23/2020** Passed the House **04/21/2020** Passed the Senate **01/08/2019** Introduced	CalOptima: Watch
H.R. 748 Courtney	**CARES Act:** Authorizes $2.2 trillion in spending for health care and employment-related interventions. This includes: ■ $1.5 billion to support the purchase of personal protective equipment, lab testing, and other activities; ■ $127 billion to provide grants to hospitals, public entities, and nonprofits, and Medicare and Medicaid suppliers and providers to cover unreimbursed health care related expenses or lost revenues due to COVID-19; ■ $1.32 billion in supplemental funding for community health centers; ■ $955 million to support nutrition programs, home and community-based services, support for family caregivers, and expanded oversight for seniors and individuals with disabilities; ■ $945 million to support research on COVID-19; and ■ $425 million to increase mental health services.	**03/27/2020** Signed into law **03/27/2020** Passed the House **03/25/2020** Passed the Senate **01/24/2019** Introduced	CalOptima: Watch
H.R. 6201 Lowey	**Families First Coronavirus Response Act:** Allocates billions of federal funding support related to COVID-19. Funds are to be utilized for an emergency increase in the Federal Medical Assistance Percentages (FMAP) for Medicaid of 6.2%, emergency paid sick leave and unemployment insurance, COVID-19 testing at no cost, food aid and other provisions. Of note, on March 6, 2020, President Trump signed into law an emergency supplemental funding package of $8.3 billion for treating and preventing the spread of COVID-19.	**03/18/2020** Signed into law **03/17/2020** Passed the Senate **03/14/2020** Passed the House **03/11/2020** Introduced	CalOptima: Watch
H.R. 6462 Cisneros, Gallegos	**Emergency Medicaid for Coronavirus Treatment Act:** Would expand Medicaid eligibility to any American diagnosed with COVID-19 or any other illness that rises to the level of a presidential national emergency declaration. Additionally, would require Medicaid coverage for all COVID-19 treatment and testing to continue even after the national emergency is over.	**04/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 6666 Rush	**COVID-19 Testing, Reaching, and Contacting Everyone (TRACE) Act:** Would authorize the Centers for Disease Control and Prevention (CDC) to award grants for testing, contact tracing, monitoring, and other activities to address COVID-19. Those eligible to receive grant funding would include federally qualified health centers, nonprofit organizations, and certain hospitals and schools. Additionally, would allocate $100 billion for fiscal year 2020 for the disbursement of CDC grant funds.	**05/01/2020** Introduced	CalOptima: Watch
SB 89 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19:** Appropriates $500 million from the 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 685 Reyes	**COVID-19 Workplace Exposure Notifications and Reporting:** Effective January 1, 2021, establishes the employer notification and reporting requirements when an employer learns of a potential COVID-19 exposure at a worksite. Specifically, an employer is required to send a notice of potential exposure to all employees who were at the same worksite. The notification must include information about workers' compensation and leave options, as well as the employer's disinfection plan. In addition, the employer must report information about diagnosed employees to the local health agency within forty-eight (48) hours of learning that at least three (3) employees working at the same site have tested positive for COVID-19 within a 14-day period.	**09/17/2020** Signed into law **08/31/2020** Passed Assembly floor **08/30/2020** Passed Senate floor **06/29/2020** Introduced	CalOptima: Watch
SB 117 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19 at Schools:** Appropriates $100 million of Proposition 98 revenues from the 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

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 275 **Pan, Leyva**	**Personal Protective Equipment:** Requires 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. Requires the stockpile to have enough supplies for no less than a 45-day pandemic or other state or local health emergency. Additionally, requires general acute care hospitals, skilled nursing facilities, integrated health systems, and licensed dialysis clinics to maintain a 45-day stockpile of PPE. Establishes the Personal Protective Equipment Advisory Committee to make recommendations to the Department of Industrial Relations and State Department of Public Health regarding necessary types and amount of PPE, procurement and supply chain resilience, storage, and other best practices.	**09/29/2020** Signed into law **08/31/2020** Passed Assembly floor **05/02/2019** Passed Senate floor **02/13/2019** Introduced	CalOptima: Watch CalPACE: Oppose
SB 1159 **Hill**	**COVID-19 Workers' Compensation Benefits:** Effective immediately and until January 1, 2023, when a qualifying employee files a workers' compensation claim for a COVID-19 diagnosis, the claim is presumed to be payable for both medical treatment and temporary disability benefits after all COVID-19-related paid sick leave has been exhausted. The employer may submit evidence to dispute the claim within forty-five (45) days of claim filing, including evidence of measures in place to reduce potential COVID-19 transmission and evidence of the employee's non-work-related risks of COVID-19 infection. Qualifying employees include: ■ Certain types of first responders and healthcare workers with a diagnosis of COVID-19. ■ Any employee who is diagnosed with COVID-19 during an outbreak of COVID-19 at the employee's worksite.	**09/17/2020** Signed into law **08/31/2020** Passed Assembly floor **06/26/2020** Passed Senate floor **04/22/2020** 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

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
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	**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 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 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Authorizes MHSA funds to include treatment of a substance use disorder for an individual with cooccurring mental health and substance use disorders, when that individual is already eligible to receive mental health services through an MHSA-funded program. The authorization applies across the state. Additionally, requires 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.	**09/25/2020** Signed into law **08/28/2020** Passed Senate floor **06/02/2020** Passed Assembly floor **02/14/2020** Introduced	CalOptima: Watch Orange County Board of Supervisors: Support
SB 803 Beall	**Mental Health Peer Support Services Certification:** Creates requirements for a Certified Peer Support Specialist (PSS) certification program by July 1, 2022. Allows an individual 18 years of age or older, who has experienced a mental illness and/or a substance use disorder or is a parent or family member of such individual, to become a PSS. A PSS is able to provide non-medical specialty mental health and substance abuse support services in a county that opts in to establish a PSS certification program and funds the non-federal share of those services. This requires the Department of Health Care Services to develop and implement billing codes, reimbursement rates, and claim requirements for the PSS program. Additionally, requires the Department to include PSS as a Medi-Cal provider type and PSS services as a distinct service type in participating counties.	**09/25/2020** Signed into law **08/31/2020** Passed Assembly floor **06/24/2020** Passed Senate floor **01/08/2020** Introduced	CalOptima: Watch LHPC: Support Orange County Board of Supervisors: Support

BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2276 Reyes	**Blood Lead Screening Tests Age Guidelines:** Requires the Medi-Cal managed care plan (MCP) to ensure blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age by doing the following: ■ Identify, on a quarterly basis, every child beneficiary that has missed a blood screening test; ■ If a test was missed, notify the beneficiary's health care provider of the requirement to perform a test and provide guidance to the parent/guardian; ■ Submit to the Department of Health Care Services, on an annual basis and upon request, a record of every beneficiary under six years of age that has missed a blood screening test, including the age at which a test was missed; and ■ If a parent/guardian declines a recommended screening, ensure that the parent/guardian signs a statement of refusal to be documented in the child's medical record.	**09/28/2020** Signed into law **08/29/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/14/2020** 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.	**1/24/2020** 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.	**1/24/2020** 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.	**1/24/2020** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4996 Kelly	**Helping MOMS Act of 2020:** Would give states the option to extend the required sixty (60) days of postpartum coverage under Medicaid to one (1) year following a pregnancy. Additionally, would require the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) to issue a report on coverage of doula services in the Medicaid program, as well as recommendations to increase access to doula services.	**09/29/2020** Passed the House **09/21/2020** Passed the Committee on Energy and Commerce **11/08/2019** 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 Committee on Financial Services	CalOptima: Watch
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the Committee on Health, Education, Labor, and Pensions	CalOptima: Watch Orange County Board of Supervisors: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2746 Petrie-Norris, Gabriel	**Accountability of State Funds Used for Homelessness:** Would have required any entity 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 standardized report regarding the use of state funds. The report would have been sent annually to the state agency granting funds for the program.	**09/29/2020** Vetoed **08/30/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/20/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2100 Wood	**Pharmacy Benefit Carve-Out (Medi-Cal Rx) Modifications:** Would have required 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 have required the IPDMRS to review grievances regarding any outpatient prescription drug benefit that was denied, modified, or delayed due to a finding that the service is not medically necessary or was experimental. Additionally, would have required a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list. Finally, would have allowed the Department to provide a disease management payment to contracted pharmacies for specialty drugs in order to ensure beneficiary access.	**09/29/2020** Vetoed **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/05/2020** Introduced	CalOptima: Watch
SB 852 Pan	**California Affordable Drug Manufacturing Act of 2020:** Requires the California Health and Human Services Agency (CHHSA) to enter into partnerships with one or more drug companies or generic drug manufacturers, licensed by the United States Food and Drug Administration, to produce or distribute generic prescription drugs, including at least one form of insulin, in order to reduce the cost of prescription drugs. Requires CHHSA to study and report to the Legislature on the feasibility of the State directly manufacturing and selling generic prescription drugs, no later than July 1, 2023.	**09/28/2020** Signed into law **08/31/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **01/13/2020** Introduced	CalOptima: Watch CAHP: Support

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	**Nurse Practitioner Scope of Practice:** Establishes the Nurse Practitioner Advisory Committee to provide recommendations and advice to the Board of Registered Nursing. Effective January 1, 2021, permits a 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, when practicing in a setting with one or more physicians. Also requires the Board of Registered Nursing to define the minimum requirements for which a nurse practitioner may transition to practice without standardized procedures within three (3) years. Effective January 1, 2023, permits a nurse practitioner to practice independently in a setting without a physician, after an additional three (3) years of practice experience.	**09/29/2020** Signed into law **08/31/2020** Passed Senate floor **01/27/2020** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

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
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 Committee on Finance	CalOptima: Watch AHIP: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2164 Rivas, Salas	**Expanding Access to Telehealth:** Would have no longer required 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 have allowed the new patient the option to utilize telehealth services and become an established patient as their first visit. This would have only applied during the COVID-19 pandemic and up to 180 days post-termination of the state of emergency.	**09/26/2020** Vetoed **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/11/2020** Introduced	CalOptima: Watch LHPC: Support
AB 2360 Maienschein	**Mothers and Children Mental Health Support Act of 2020:** Would have created a provider-to-provider telehealth consultation program for use when assessing mental health and/or providing mental health treatments for children, pregnant women, and postpartum persons, effective no sooner than July 1, 2021. Would have permitted telehealth services to be conducted by video or audio-only calls. Additionally, would have required the telehealth consultation appointment to be completed by a mental health clinician with expertise in providing care for pregnant, postpartum, and pediatric patients. Would have required access to a psychiatrist when deemed appropriate or requested by the treating provider.	**09/26/2020** Vetoed **08/28/2020** Passed Senate floor **06/10/2020** Passed Assembly floor **02/19/2020** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

*Information in this document is subject to change as bills are still going through the 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

Last Updated: November 10, 2020

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
December 3, 2020

CalOptima Community Outreach Summary — November

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 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

To engage and support our community partners during these challenging times, the Community Relations department will host a virtual Community Alliance Forum on Wednesday, December 9, 2020 from 9–11 a.m. The focus of the forum will be “Mental Health and Self-Care During Uncertain Times.”

The Community Alliances Forum is a quarterly networking event with the goal of strengthening, developing and sustaining positive relationships with community-based organizations, health care providers, policy makers, and other individuals/organizations that care about community health. The forum provides attendees an opportunity to address and discuss health issues impacting the county, share information and resources, and strengthen individual knowledge and skills.

Betsy Ha, CalOptima’s Executive Director of Quality and Population Health Management will open the event by providing an update on CalOptima’s efforts to collaborate with community partners to promote awareness and utilization of the Adverse Childhood Experiences (ACEs) screening tool. Attendees will also have an opportunity to experience a Mindful Moment with Betsy, who will lead the group in an experience of mindfulness and compassion meditation.

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Our panel of presenters will include: Lauren Brand, Director of Operations at Mind OC who will provide an update on Be Well OC, the Regional Wellness Hubs, and efforts to create a countywide, coordinated ecosystem to support the mental health needs of Orange County residents; and, Dr. Clayton Chau, Director of the Orange County Health Care Agency and acting County Health Officer, who will discuss the impacts of provider fatigue, the importance of self-care, and tools to practice and maintain self-care through the holidays.

CalOptima recognizes the importance of supporting our community partners' mental health during these challenging times and look forward to highlighting this important topic. 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 October 19, 2020, **through virtual meetings and teleconferences** CalOptima expects to participate in 27 community events, coalition and committee meetings during November.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
11/03/2020	• Collaborative to Assist Motel Families (Virtual Meeting)
11/05/2020	• Continuum of Care Homeless Provider Forum (Virtual Meeting) • Garden Grove Community Collaborative Advisory Meeting (Virtual Meeting)
11/09/2020	• Orange County Veterans and Military Families Collaborative — Children and Family Working Group (Virtual Meeting) • Fullerton Collaborative Meeting (Virtual Meeting)
11/10/2020	• Orange County Cancer Coalition Meeting (Virtual Meeting) • Wellness and Prevention Coalition Meeting (Virtual Meeting)
11/12/2020	• Buena Park Collaborative Meeting (Virtual Meeting) • Garden Grove Collaborative Meeting (Virtual Meeting) • Kid Healthy Community Advisory Committee Meeting (Virtual Meeting) • State Council on Developmental Disabilities Regional Advisory Committee Meeting (Virtual Meeting)
11/13/2020	• Senior Citizens Advisory Council General Meeting (Virtual Meeting)
11/16/2020	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting (Virtual Meeting)
11/17/2020	• North Orange County Senior Collaborative Meeting (Virtual Meeting) • Placentia Community Collaborative Meeting (Virtual Meeting)

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	• Aging and Disability Resource Connection Advisory Committee Meeting (Virtual Meeting) • Fall Conference hosted by California Association for Adult Day Services (Sponsorship fee: $500 included listing agency's logo and link with website in conference materials and a quarter page ad in event program) (Virtual Event)
11/18/2020	• Covered Orange County Steering Committee Meeting (Virtual Meeting) • Orange County Communications Workgroup (Virtual Meeting)
11/19/2020	• Orange County Children's Partnership Meeting (Virtual Meeting) • Orange County Women's Health Project Advisory Meeting (Virtual Meeting)
11/23/2020	• Stanton Collaborative Meeting (Virtual Meeting)
11/26/2020	• Orange County Care Coordination for Kids Collaborative Meeting (Virtual Meeting)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff/ Volunteer to Attend	Events/Meetings
11/10/2020	1 Staff	• Together4Teens Event — Teen Mental Health and COVID-19 hosted by the Wellness and Prevention Coalition, November 10 and November 12, 2020 (Sponsorship fee: $1,000 included agency logo on flier, ad in the virtual directory and featured on social media) (Virtual Event)
11/12/2020	1 Staff	• Community Health and Resource Fair hosted by Clinton Corner Family Campus (Virtual Event) • Together4Teens Event — Digital Parenting During COVID-19, November 10 and November 12, 2020 (Sponsorship fee: see above) (Virtual Event)
11/13/2020	NA	• Senior Week Health Fair hosted by the Institute for Healthcare Advancement (Sponsorship fee: $1,000 included placement of agency's logo with link on website on the bottom of event sponsorship pages and on event marketing materials) (Drive-thru Event)

As of October 19, 2020, CalOptima expects to organize or convene seven community stakeholder events, meetings or presentations through virtual meetings or teleconferences during November.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
11/03/2020	• CalOptima Deep Dive Community Presentation (Part 1) (Virtual Platform)

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11/04/2020	• CalOptima Deep Dive Community Presentation (Part 2) (Virtual Platform)
11/10/2020	• CalOptima Resource Fair — Health Services and Resources for Individuals Experiencing Homelessness (Virtual Platform)
11/18/2020	• CalOptima Resource Fair — Legal Resources and Veteran Services for Individuals Experiencing Homelessness (Virtual Platform)
11/19/2020	• Health Network Forum (Virtual Platform) • CalOptima Resource Fair — General Resources for Individuals Experiencing Homelessness (Virtual Platform)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	**Events/Meetings/Presentations**
11/19/2020	• Great American Smokeout — 2020 Escape the Vape (Virtual Platform)

CalOptima provided one endorsement consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

1. Provide use of CalOptima name or logo in a letter to the Department of Health Care Services on best practice recommendations for Behavioral Health Therapy for children under Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.

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CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the opportunity to increase awareness of 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 has transitioned how we engage with our community partners and is not 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 continues its participation in community collaborative meetings and community events by attending virtual meetings and events; CalOptima also looks for additional ways to support our community partners by providing CalOptima informing materials and, if requested and criteria are met, by providing branded items. 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 were 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.1223 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.

December

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Ongoing Virtual Event	*Say Hello to OneCare Connect	Community Presentation Open to the Public	N/A	www.caloptima.org /onecareconnect
Tuesday, 12/1 9–10:30 a.m. (Virtual format)	*Cafecito Meeting	Steering Committee Meeting: Open to Collaborative Members	3 Staff	Virtual Platform
Wednesday, 12/2 9 – 10:30 a.m. (Virtual format)	++ OC Aging Services Collaborative General Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 12/2 10 a.m.–12 p.m. (Virtual format)	++Anaheim Human Services Network Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 12/2 10:30 a.m.–12 p.m. (Virtual format)	++ Orange County Healthy Aging Initiative/OCSPA Healthcare Committee	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Alzheimer's OC 1515 McCabe Way Irvine
Thursday, 12/3 9–10 a.m. (Virtual format)	*CalOptima Resource Fair – Basic Needs for Individuals Experiencing Homelessness	Health/Resource Fair Open to CalOptima and Health Network Staff Registration required	3+ Staff	Virtual Platform
Thursday, 12/3 9–11 a.m. (Virtual format)	++Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 12/3 11 a.m.–1 p.m. (Virtual format)	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Courtyard Center 12732 Main St. Garden Grove

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Tuesday, 12/8 10–11:30 a.m. (Virtual format)	++Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Susan G. Komen OC 2817 McGaw Ave. Irvine
Tuesday, 12/8 3:30–5:30 p.m. (Virtual format)	++Wellness and Prevention Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	189 Avenida La Cuesta San Clemente
Wednesday, 12/9 9–11 a.m. (Virtual format)	*Community Alliance Forum	Community Presentation Registration requested	6+ Staff	The Delhi Center 505 Central Ave. Santa Ana
Wednesday, 12/9 12–1:30 p.m. (Virtual format)	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Anaheim Central Library 500 West Broadway Anaheim
Thursday, 12/10 10:00–11:30 a.m. (Virtual format)	++Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Buena Park Community Center 6640 Beach Blvd. Buena Park
Thursday, 12/10 11:30 a.m.–12:30 p.m. (Virtual format)	++Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 12/10 12:30–1:30 p.m. (Conference call)	++Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Hive 1725 S. Douglas Rd. Anaheim
Thursday, 12/10 2:30–4:30 p.m. (Virtual format)	++Orange County Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Village in Santa Ana 1505 E. 17th St. Santa Ana
Monday, 12/14 12:30–1:30 p.m. (Virtual format)	++Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Stanton Civic Center 7800 Katella Ave. Stanton
Monday, 12/14 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	1 Staff	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 12/14 2:30–3:30 p.m. (Virtual format)	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Fullerton Library 353 W. Commonwealth Ave. Fullerton

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Tuesday, 12/15 11 a.m.–12 p.m. (Conference call)	++Placentia Community Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Placentia Library 411 Chapman Ave. Placentia
Tuesday, 12/15 1-2:30 p.m. (Virtual format)	++Aging and Disability Resource Connection Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual Platform
Wednesday, 12/16 9–10:30 a.m. (Conference call)	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	1 Staff	The Village 1505 E. 17th St. Santa Ana
Wednesday, 12/16 11 a.m.–12 p.m. (Conference call)	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual Platform
Wednesday, 12/16 3:30–4:30 p.m. (Conference call)	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Location varies
Thursday, 12/17 1:30–3:30 p.m. (Virtual format)	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	2 Staff	CHOC Centrum Building 1120 W. La Veta Orange
Monday, 12/21 1–4 p.m. (Virtual format)	++ OCHCA Mental Health Services Act Steering Committee	++ OCHCA Mental Health Services Act Steering Committee	1 Staff	Delhi Community Center 505 E. Central Ave. Santa Ana
Tuesday, 12/22 9–10:30 a.m. (Virtual format)	++Clinic in the Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	1 Staff	Virtual Platform

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

16. Consider Authorizing an Amended and Restated Health Network Contract for Kaiser Foundation Health Plan Inc. and Amendments Incorporating Operational Provisions and Revised Capitation Rates

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to ~~enter into~~:

Rev. 12/3/20

Amend the current Kaiser Foundation Health Plan, Inc. Health Network Contract to extend the term through the date of the next Regular CalOptima Board meeting, February 4, 2021.

~~1. An Amended and Restated Medi-Cal Health Network Contract with Kaiser Foundation Health Plan, Inc., incorporating language changes, effective July 1, 2019 through June 30, 2021; and~~

~~2. Amendments incorporating all changes made in the Health Network contracts since July 1, 2019, along with revised capitation rates and certain operational requirements effective January 1, 2021.~~

Background

Kaiser Foundation Health Plan Inc. (Kaiser) participates in CalOptima's Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization (HMO) Health Network model. CalOptima's health network contracts are renewed on an annual basis each July, subject to Board approval. On June 6, 2019, the CalOptima Board authorized an Amended and Restated Contract with all Health Networks. The Board has approved five (5) Amendments to the Amended and Restated Health Network Contract since that time.

Kaiser did not, however, execute the Amended and Restated Contract or the five (5) subsequent Amendments and, instead, engaged CalOptima staff in a series of discussions regarding certain contract terms. The Board authorized extensions of the existing contract on August 6, 2020, October 1, 2020, and November 5, 2020 to accommodate continued contract discussions. The latest extension is effective through December 3, 2020.

Discussion

Kaiser and CalOptima staff have had extensive discussions and have come to an agreement regarding the terms of the Amended and Restated Contract. The document has been revised and some terms updated to address legacy language and operational requirements addressing Kaiser's business model. Board authorization to execute the Amended and Restated Contract effective July 1, 2019 through June 30, 2021 is now requested. Authorization is also sought to execute Amendments I through V, including language addressing capitation rate changes based on CalOptima's rebasing efforts consistent with prior

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Health Network rate changes and operational requirements, including extending funding for the health Homes Program, revising the Division of Financial Responsibility, and increasing the notice period for termination for convenience. The revised capitation rates and operational requirements will be effective January 1, 2021, and the Amended and Restated Contract will be in effect through June 30, 2021 consistent with all of CalOptima's other Health Network Contracts.

Fiscal Impact

The recommended action to retroactively enter into the Board-approved Amended and Restated HMO Health Network Contract with Kaiser effective July 1, 2019, through June 30, 2021, and execute five amendments containing language changes from subsequent amendments is a budgeted item. Funding for the contract and related amendments is consistent with the Board-approved rebasing exercise and has been included in the Board-approved Fiscal Year (FY) 2019-20 and FY 2020-21 Operating Budgets.

Rationale for Recommendation

Authorization to execute the Amended and Restated Medi-Cal Health Network Contract and update capitation rates will ensure that Kaiser is operating under the current contractual terms and conditions as required by CalOptima's regulators and operational requirements, and will implement the rebased capitation rates.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated November 5, 2020; "Consider Authorization of a Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term," which includes the following attachments:
   - Previous Board Action dated October 1, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term"
   - Previous Board Action dated August 6, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment"
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"
4. Previous Board Action dated April 2, 2020; "Consider Actions Related to Coronavirus (COVID-19) Pandemic"
5. Previous Board Action dated March 5, 2020; "Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation"
6. Previous Board Action dated October 3, 2019; "Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation

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to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program"

7. Previous 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 Transportation (GEMT)"
8. Previous Board Action dated June 27, 2019; "Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network"
9. Previous Board Action dated June 6, 2019; "Consider Authorizing Amended and Restated Medi-Cal Health Network Contract for Kaiser Foundation Health Plan, Inc to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates"

/s/ Richard Sanchez — *11/25/2020*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorization of a Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term

Contact

Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action

Authorize amendment to the current Kaiser Foundation Health Plan, Inc. Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, December 3, 2020.

Background

Kaiser Foundation Health Plan, Inc. (Kaiser) participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020. As of the last Board of Directors' Meeting, on October 1, 2020, it was determined that review of certain provisions in the Amended and Restated contract was still in progress. As such, an additional month-long extension was requested until November 5, 2020.

Discussion

The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Proposition 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by November 5, 2020, additional time is required to fully explore whether the parties will be able to resolve and finalize the remaining issues. Staff has requested an additional month-long extension of the current

Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract Amendments to the Board for approval at the December 3, 2020 meeting, Staff requests that the Board approve extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to authorize extension of the current Kaiser Health Network Contract to through December 3, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through December 3, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

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 the Kaiser Foundation Health Plan, Inc. Health Network Contract"
3. Previous Board Action dated October 1, 2020; "Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term.

/s/ Richard Sanchez — *10/28/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

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Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

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Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

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 — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

c. Current CalOptima members age of 21 and over who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

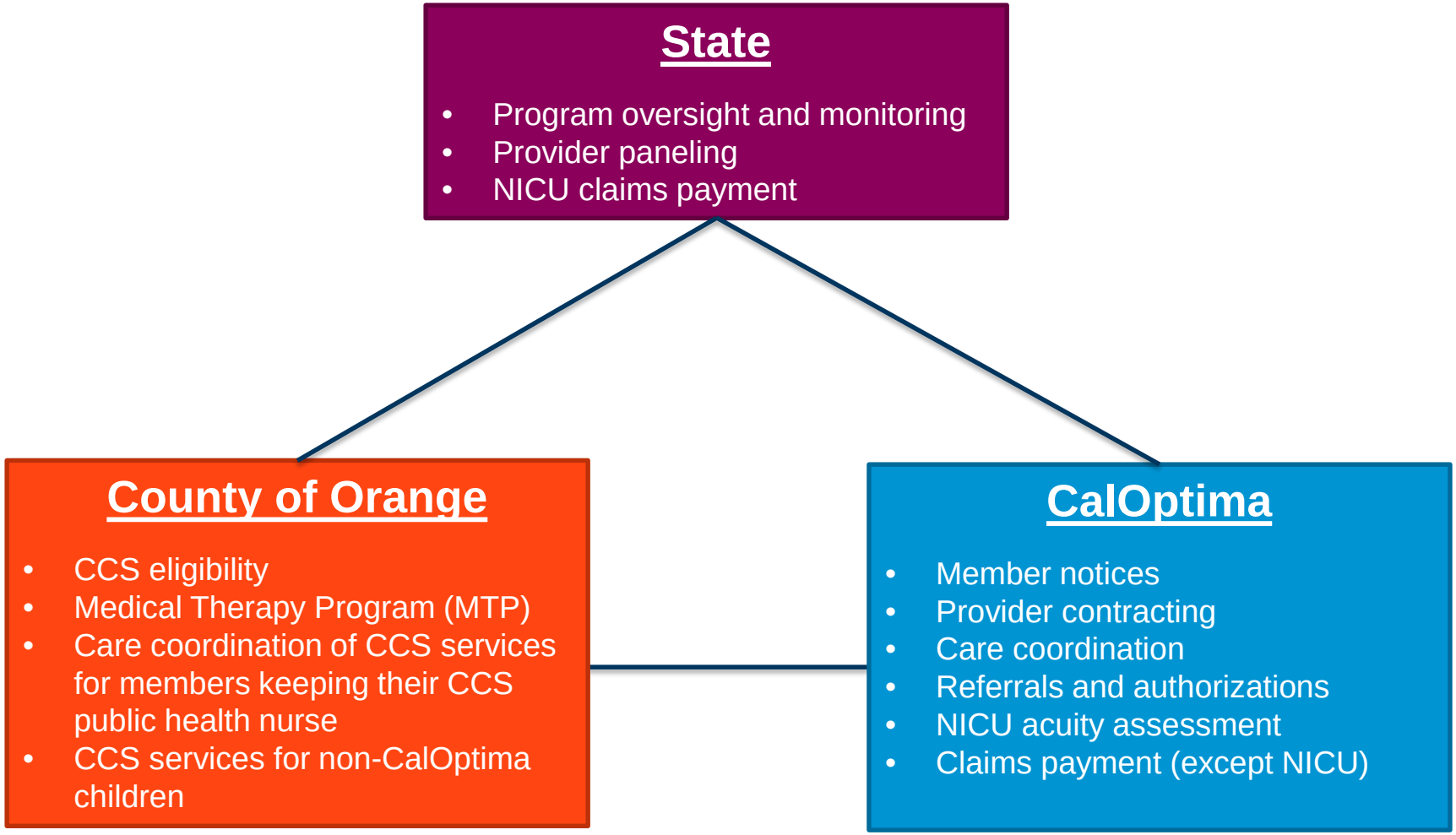
Back to Agenda Back to Item

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
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• 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

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

CalOptima
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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
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

c. Current CalOptima members age of 21 and over who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

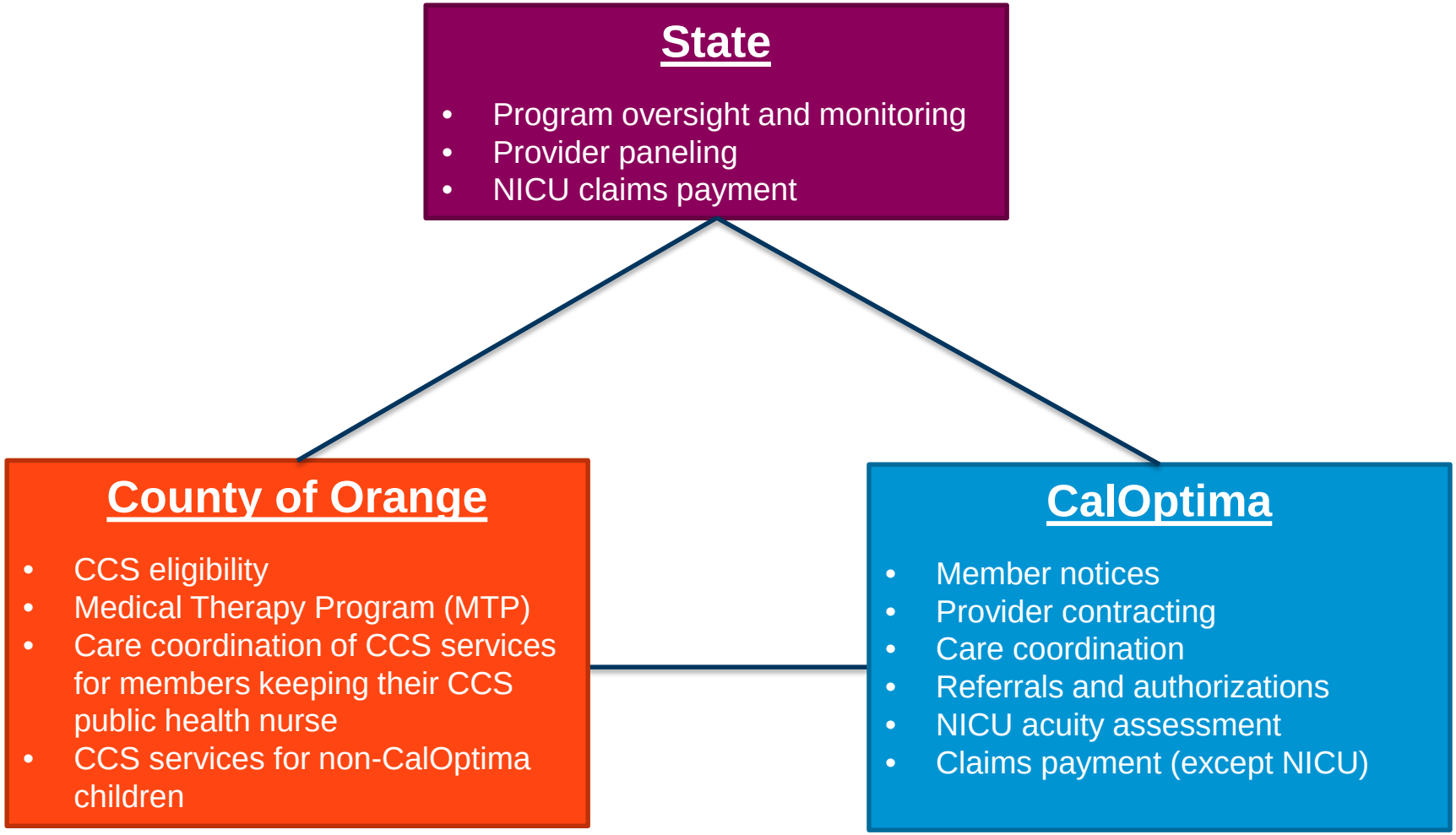
Back to Agenda Back to Item

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
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• 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

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.)

CalOptima
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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
_____ Name of Evaluator	Total Points Awarded	_____

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

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

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M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

Back to Agenda Back to Item

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

* Terms in **bold** are included in the Glossary.

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III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. C. Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)

Contact

Julie Bomgren, Director, Government Affairs, (714) 246-8400

Recommended Actions

1. Authorize and Direct the Chief Executive Officer (CEO) to execute a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous 12 months.
2. Authorize and Direct the CEO to execute an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement.
3. Authorize and direct the CEO to enter into an amendment of the current Medi-Cal agreement with Kaiser consistent with these agreements.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In 1995, CalOptima entered into an agreement with Kaiser to provide health care services under CalOptima's Medi-Cal program. As a Health Network for Medi-Cal, Kaiser currently provides health care services, including pharmacy services to approximately 11,500 CalOptima Medi-Cal members. Along with CalOptima, Kaiser is a health plan in the HFP and serves approximately 13,500 HFP children in Orange County. With the elimination of HFP, and in accordance with the HFP transition implementation plan, children enrolled in Kaiser HFP will transition to CalOptima in Phase 2, anticipated to occur no sooner than April 1, 2013.

Discussion

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

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DHCS/Kaiser/Plan Agreement

The first agreement is, by its own terms, a nonbinding agreement, between DHCS, Kaiser and the managed care plans. This template has already been signed by DHCS and Kaiser. It indicates that it sets forth a framework for a seamless transition of care for current Kaiser members in the HFP and Medi-Cal beneficiaries who were Kaiser members or family-linked within the previous twelve months.

The three-way agreement includes the following provisions:

1. DHCS, Kaiser and managed care plans will work to develop a contract template for the subcontract between plans and Kaiser.
2. A centralized oversight and compliance process to include a uniform policies and procedures audit program will be created to oversee Kaiser's obligations under the contract template (it may be necessary for two processes, one for Northern California and one for Southern California). The agreement indicates that this process will be conducted and funded by DHCS unless otherwise agreed to by the parties.
3. A process will be developed to improve the existing and future enrollment processes for Kaiser members including a validation process (of the applicant's eligibility to choose Kaiser).
4. In COHS counties including Orange County, the enrollment process for current/previous Kaiser members will mimic the existing process for all Medi-Cal members. The COHS plans such as CalOptima will assign to Kaiser new Medi-Cal members currently or previously enrolled with Kaiser in the previous twelve months or family-linked in the previous twelve months. This auto assignment to Kaiser is contingent upon COHS plans receiving required and accurate data from Kaiser and federal and state regulators. COHS members will be assigned to Kaiser only upon verification of previous coverage by Kaiser.
5. The agreement does not restrict the ability of Medi-Cal beneficiaries to choose a different provider than Kaiser during or after the beneficiary has been assigned to CalOptima.

Kaiser/Plan Agreement

The second agreement, between Kaiser and the managed care plan, is titled "Care Continuity Agreement" and defines the beneficiaries for whom the managed care plan will ensure transition to Kaiser as: 1) all members of CalOptima currently assigned to Kaiser; 2) individuals who are eligible for Medi-Cal on and after January 1, 2014 under Medi-Cal expansion and who enroll in CalOptima and are assigned to Kaiser; 3) HFP beneficiaries who are Kaiser members on the effective date of the transition; and 4) beneficiaries who are eligible for Medi-Cal or HFP after the effective date of the transition and who were Kaiser members or family-linked within the previous twelve months. This agreement has been signed by Kaiser but does not include aid codes on the attachments.

The two-way agreement includes the following provisions:

1. Kaiser will provide rate development template (RDT) data to managed care plans for inclusion in the plan RDT for the rate setting process.

2. Effective July 1, 2013, for aid codes not directly funded through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), an administrative withhold by the managed care plan will not exceed 2% of the net capitation Medi-Cal amount (the withhold may be based on the plan risk-adjusted equivalent of the net capitation amount). For aid codes directly funded through CHIPRA, there will be no administrative fee withhold.
3. Managed care plan contracts with Kaiser will be amended to include these provisions. However this Agreement indicates that it may be terminated only upon execution of an amendment to the parties, and that the terms of this Agreement will be re-evaluated in five years.
4. Kaiser may enter into a direct contract with DHCS if Kaiser is unable to reach a subcontracting agreement with Plan.

Upon approval by the Board of Directors, CalOptima modified its Medi-Cal auto assignment policy to accommodate the transition of HFP members and to the extent possible, preserve the provider/member and member/health network relationships. For children transitioning from other HFP health plans to Medi-Cal, CalOptima anticipates that DHCS will provide the Medi-Cal health plan a file that will include the incoming health plan code and name for transitioning HFP children. In order to ensure a seamless transition of care for Kaiser members, it will be necessary that CalOptima receive a timely, clean file for processing. Otherwise, CalOptima staff will follow our standard new member auto assignment process.

Fiscal Impact
With Kaiser's current membership, the 2% administrative withhold provision equates to approximately $250,000 annually which is one-half of the amount regularly included in DHCS capitation rates for administration. However, as an HMO, Kaiser will perform some of the functions that CalOptima would normally be responsible for, which will reduce CalOptima's cost accordingly.

Rationale for Recommendation
These template agreements were negotiated with DHCS, Kaiser and managed care plans and the provisions for transitioning HFP members are consistent with the requirements included in the recent amendment to CalOptima's Primary Agreement with DHCS related to the transition of HFP subscribers into Medi-Cal.

Concurrence
Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
26. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment Extending the Term

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

Recommended Action
Ratify the amendment to the current Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network Contract to extend the current term through the date of the next CalOptima Board meeting, November 5, 2020.

Background
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Kaiser's current Health Network Contract expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS-required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments.

CalOptima and Kaiser staff worked with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. To allow time for Kaiser and CalOptima to obtain all necessary information and final clarification from DHCS and complete discussions regarding the Amended and Restated Contract, the parties entered into an initial ninety (90) day extension of Kaiser's current contract through September 30, 2020. Due to the June 30, 2020 expiration date of the current Kaiser Health Network Contract, this extension was ratified by the Board on August 6, 2020.

Discussion
The parties continue to review certain provisions of the Amended and Restated Contract that memorialize operational requirements in light of Kaiser's unique model as well as the five (5) subsequent amendments that implement Prop 56, Health Homes Program requirements and other terms (Contract Amendments). Additionally, because Kaiser is the only CalOptima Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser staff are addressing terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract when the State implements its Medi-Cal Rx program effective January 1, 2021 including, revised rates and DHCS-mandated transition terms.

While CalOptima and Kaiser staff have attempted to complete all contract and amendment revisions by September 30, 2020, it will take another thirty (30) days to finalize these issues. Kaiser has requested an additional thirty (30) day extension of the current Kaiser Contract on the same terms and conditions to complete the discussions and finalize the Amended and Restated Contract and Contract Amendments. Because Staff intends to present the final Kaiser Amended and Restated Contract and Contract

Amendments to the Board for approval at the November 5, 2020 meeting, Staff requests that the Board ratify the extension of the current Kaiser Health Network Contract through that date.

Fiscal Impact

The recommended action to amend the current Kaiser Health Network Contract to extend the term through November 5, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Amending the current Kaiser Health Network Contract to extend through November 5, 2020, the date of the Board's next meeting, under the same terms and conditions will allow the additional time needed to review and finalize Kaiser's FY 2020-21 Amended and Restated Health Network Contract.

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 the Kaiser Foundation Health Plan, Inc. Health Network Contract"

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Actions
Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion
Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact
The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

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Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

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emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

/s/ Michael Schrader — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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

Back to Agenda Back to Item

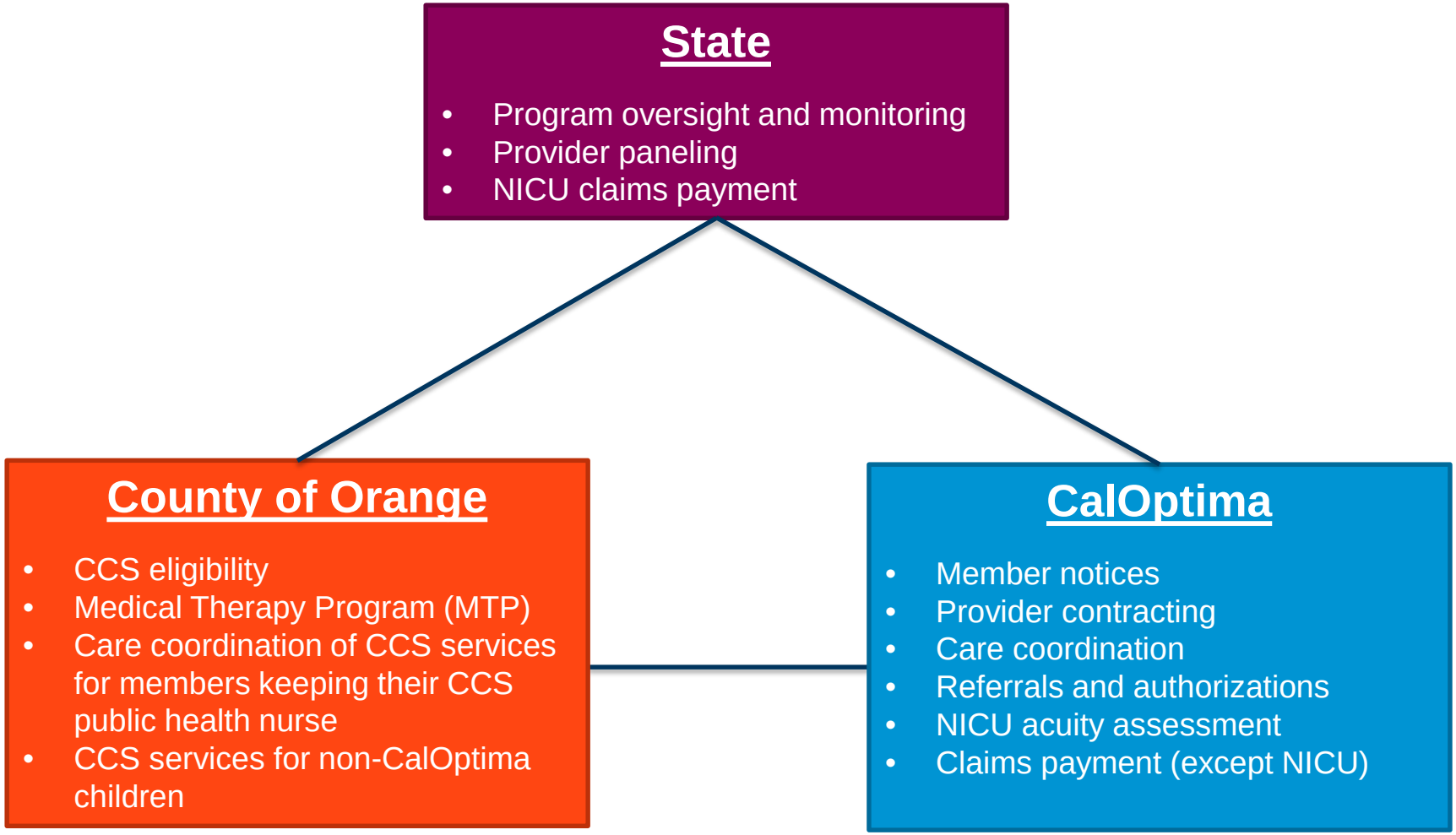
Background

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
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• 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

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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.)

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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
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

Back to Agenda Back to Item

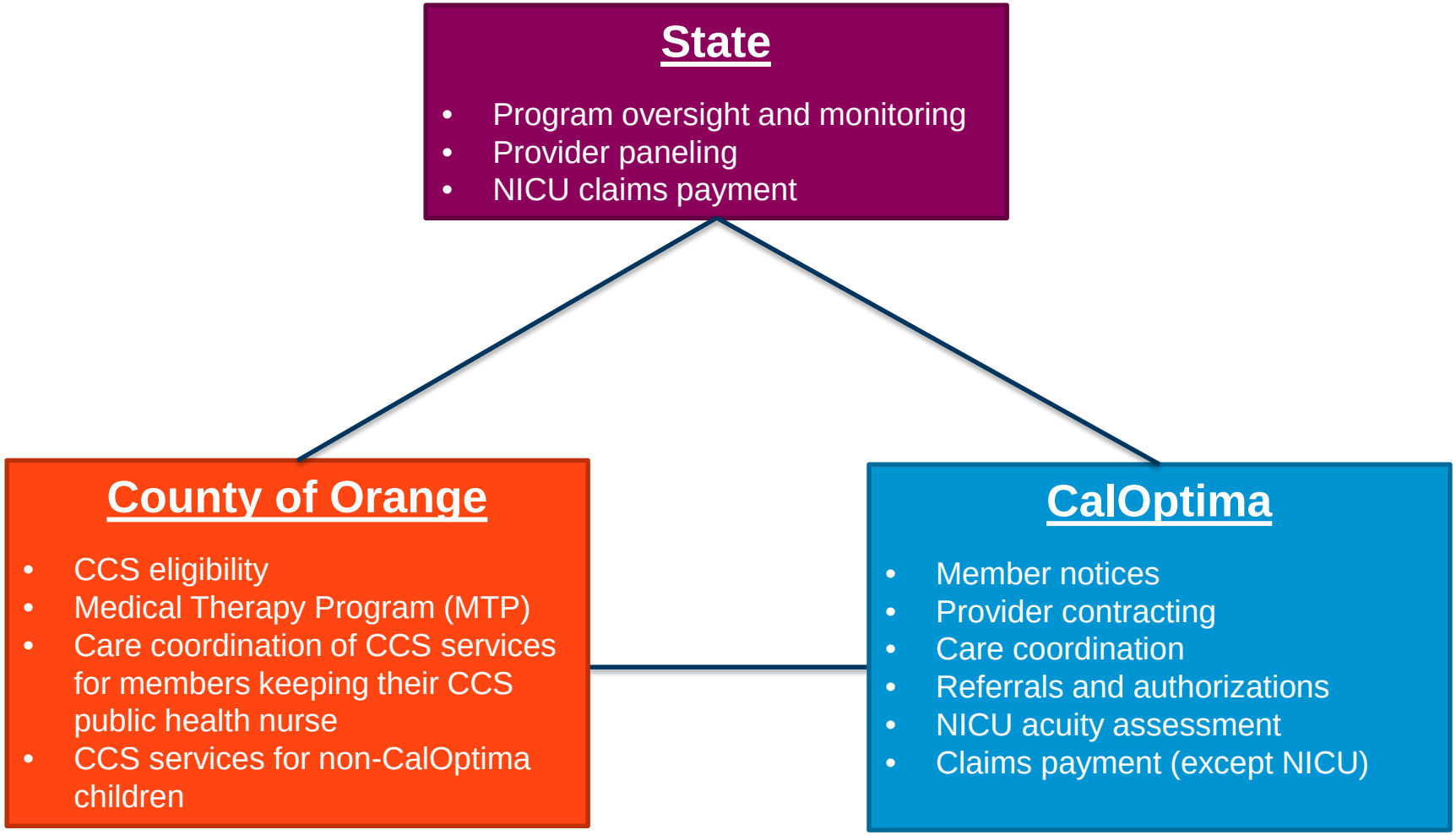
Background

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
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• 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

Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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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
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

Back to Agenda Back to Item

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

* Terms in **bold** are included in the Glossary.

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III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. C. Authorize and Direct the Chief Executive Officer to Execute Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan (Kaiser)

Contact

Julie Bomgren, Director, Government Affairs, (714) 246-8400

Recommended Actions

1. Authorize and Direct the Chief Executive Officer (CEO) to execute a three-way agreement with the DHCS and Kaiser related to the transition of Healthy Families Program (HFP) children and Medi-Cal beneficiaries who are former Kaiser members or family-linked within the previous 12 months.
2. Authorize and Direct the CEO to execute an agreement with Kaiser related to transitioning certain defined categories of members to Kaiser as described in the two-way agreement.
3. Authorize and direct the CEO to enter into an amendment of the current Medi-Cal agreement with Kaiser consistent with these agreements.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In 1995, CalOptima entered into an agreement with Kaiser to provide health care services under CalOptima's Medi-Cal program. As a Health Network for Medi-Cal, Kaiser currently provides health care services, including pharmacy services to approximately 11,500 CalOptima Medi-Cal members. Along with CalOptima, Kaiser is a health plan in the HFP and serves approximately 13,500 HFP children in Orange County. With the elimination of HFP, and in accordance with the HFP transition implementation plan, children enrolled in Kaiser HFP will transition to CalOptima in Phase 2, anticipated to occur no sooner than April 1, 2013.

Discussion

In June 2012, the Legislature passed Assembly Bill (AB) 1494 which provides for the transition of all HFP subscribers to Medi-Cal.

In June 2012, Kaiser approached the State to consider the development of an agreement whereby Kaiser will retain its HFP members upon their transition into Medi-Cal through a direct contractual relationship with DHCS. As a direct contractual relationship in the existing managed care county delivery systems throughout California is not possible due to state and federal statutes, DHCS, Kaiser and the Medi-Cal managed care plans developed two agreements to address the HFP transition and future Medi-Cal enrollment.

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 April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact
Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

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

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background
On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

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

03/26/2020 — **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

1. Ratify amendments to the Medi-Cal health network contracts, except AltaMed Health Services Corporation, to include payment by CalOptima of startup costs associated with the Whole-Child Model program; and,
2. Ratify the expenditure of up to $1.75 million in IGT 6 and 7 funds for implementation.

Background

The California Children's Services Program (CCS) is a statewide program, providing medical care, case management, physical/occupational therapy, and financial assistance for children up to age 21 meeting financial and health condition eligibility criteria. Following the approval of Senate Bill 586 in September 2016, the Department of Healthcare Services (DHCS) was given the authority to incorporate a number of CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS), referred to as the Whole Child Model (WCM). CalOptima began the process of transitioning its Medi-Cal Health Networks in June 2018, with implementation going live as of July 1, 2019. The importance of a successful WCM transition cannot be overstated, as it directly impacts the wellbeing of CalOptima's most at-risk pediatric members.

IGTs are transfers of public funds between eligible governmental entities, which qualify for matching federal funds for the Medi-Cal program. IGT 6 and 7 funds were received in May 2018 from the Department of Health Care Services (DHCS) totaled $31.1 million. After initial disbursements of $10 million for the Homeless Health Initiative, the Board authorized the remaining balance of $21.1 million to be used for community grants, internal initiatives and program administration. On August 1, 2019, the Board authorized $1.75 million for the Whole Child Model Assistance for Implementation and Development (WCM AID), which was approved as an internal initiative. The funds were designated to aid health networks in developing and implementing a successful delivery system for the WCM program.

Discussion

Health networks were required to cover a portion of the WCM program's startup expenses incurred before the launch on July 1, 2019. Following the Board's August 1, 2019 approval of the IGT 6 and 7 allocation for WCM startup costs, health networks were notified that they would receive a one-time, fixed payment of $50,000, plus applicable variable costs up to the amount allowed per network based on the number of WCM assigned members. CalOptima provided criteria for reimbursement, including

receipt of attestations demonstrating that the costs were incurred prior to the WCM program go-live date of July 1, 2019, and that expenditures fall within the specified categories of:

- Staffing, recruitment and training.
- Systems and infrastructure.
- Other expenses such as educational materials, notices, etc.

Staff seeks authority to ratify contract amendments and expenditures for the Medi-Cal health networks, except AltaMed Health Services Corporation, to aid with start-up costs and implementation of the WCM program.

Fiscal Impact

The recommended action to amend Medi-Cal health network contracts to include disbursement of IGT 6 and 7 funds for WCM Assistance for Implementation and Development has no fiscal impact to CalOptima's operating budget. The Board authorized the allocation of $1.75 million from IGT 6 and 7 funds for this purpose at the August 1, 2019, meeting. 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

The recommended action ensures CalOptima's Medi-Cal health network contracts are updated to reflect receipt of IGT 6 and 7 funds for reimbursement of startup costs associated with the WCM program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 3, 2017; 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
3. Previous Board Action dated August 1, 2019; Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

/s/ Michael Schrader — *02/26/2020*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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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.

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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 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.

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**

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CalOptima
A Public Agency
Better. Together.

IGT 6 and 7 Community Grant Award Recommendations

August 1, 2019

Candice Gomez
Executive Director, Program Implementation

Background

- 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
- 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.)

- 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

RFP Evaluation Criteria

- 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

Site Visits

- 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

RFP Summary

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**

1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)

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**

2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)

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**

3. Increase Access to Medication-Assisted Treatment ($6 million)

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**

5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)

Rank	Organization	Original Request	Recommended Funding Amount
1	Serve the People	$1,000,000	$1,000,000
	Total	**$1,000,000**	**$1,000,000**

No Funding for RFPs 4 and 6

- 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

Internal Projects ($2.4 million)

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**

Recommended Board Actions

- 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.

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

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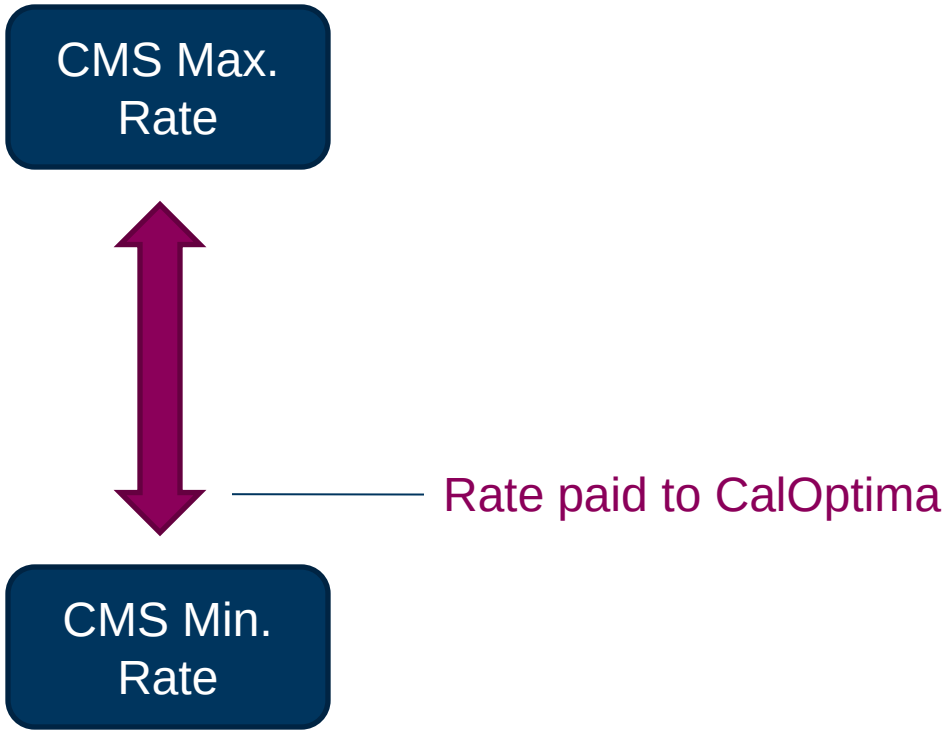
Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

CalOptima Share Totals To-Date

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**

IGT 1 Status

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**	

As of 5/31/2017

IGT 2 Status

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**	

As of 5/31/2017

IGT 3 Status

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**	

As of 5/31/2017

IGT 4 Status

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

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IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- 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)

- 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

Member Health Needs Assessment (IGT 5)

- 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

Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population

Opioid/Other Substances Overuse

- 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

- 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

- 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

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

Homeless Health

- 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
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

Competitive Community Grants

- 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

CalOptima Projects and Program Admin

- 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

Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

CalOptima's 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 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.

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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**

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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**

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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**

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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 — **Authorized Signature**

8/29/2018 — **Date**

IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

IGT 6 & 7 - Background

- 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

IGT 6 & 7 Funding

- **$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

IGT 6 & 7 LOI Summary

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	**117**

Children's Mental Health – 2 RFPs

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**

* Multiple awardees may be selected per RFP

RFP 1

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

RFP 2

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

Opioid & Other Substance Overuse – 1 RFP

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	$6.0 million
	Total	**$6.0 million**

*Multiple awardees may be selected per RFP

RFP 3

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

Community Needs Identified by MHNA: Food Access – 3 RFPs

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**

*Multiple awardees may be selected per RFP

RFP 4

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

RFP 5

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

RFP 6

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

Internal Projects/Program Admin.

Description	Amount
IS and Other Infrastructure Projects	$2.5 million
Support for staff and administrative costs	~$315K/year (for 3 years)

Next Steps*

- 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

* Dates are subject to change based on Board approval

Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

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*

Current System of Care (Cont.)

- 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)
- 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

- 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

Immediate Response

- 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

Strengthened System of Care

- 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”)

Federal and State Guidance

- 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

Federal and State Guidance (Cont.)

- 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)

Activities in Other Counties

- 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

Considerations

- 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

Additional Considerations

- 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

Recommended Actions

- 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~~
- 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.)

- 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

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

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.

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 October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Amendments to Medi-Cal Health Network Contracts Except Those Associated with AltaMed Health Services Corporation to Include Language for the Health Homes Program and Consider Ratifying Memorandum of Understanding with HCA Related to the Health Homes Program

Contact

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 the CalOptima Medi-Cal Health Network Contracts, except those associated with AltaMed Health Services Corporation, to provide Health Homes Program (HHP) services, including responsibilities as Community Based-Care Management Entities (CB-CMEs), as well as include all subcontracting requirements of the California Department of Health Care Services (DHCS);
   b. Amend the Business Associate Agreements, as necessary, for network data sharing; and
2. Ratify the Behavioral Health Memorandum of Understanding (MOU) amendment with the Orange County Health Care Agency to reflect coordination of services for CalOptima members with mental health conditions who enroll in the Health Homes Program, effective October 1, 2019.

Background/Discussion

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option, which is intended to improve member outcomes and reduce health care costs with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020 for CalOptima Medi-Cal members with eligible chronic physical conditions and substance use disorders (SUD), and no sooner than July 1, 2020 for CalOptima Medi-Cal members with Serious Mental Illness (SMI).

HHP Eligible Members and HHP Enrollment

Members with certain chronic physical conditions, SUD and SMI and meeting specified medical condition acuity requirements may qualify to participate in HHP. In order to participate, members must actively choose to enroll into HHP. Based on DHCS eligibility criteria, CalOptima staff plans to actively outreach to Medi-Cal only members potentially eligible for HHP and actively engage these members through written, telephonic, and face-to-face encounters to encourage member participation in HHP. CalOptima anticipates that approximately 30,000 Medi-Cal only members will be potentially eligible for HHP and that approximately 10% -25% of these eligible members will elect to participate. HHP eligible members who are currently in Whole Person Care Pilot program can also elect to enroll in HHP, however services provided under both programs cannot be duplicated. CalOptima's dually eligible

members can be referred to participate in HHP by community providers if members meet HHP eligibility criteria.

HHP Network Delivery Model
In developing CalOptima's HHP strategy, staff has considered the impact of these new HHP requirements to CalOptima's current delivery system. The impact analysis has included reviewing staffing resources, process and system enhancements, data exchange, and available community resources for new HHP services, such as accompaniment to appointments, housing transition services and tenancy sustaining services. Many of the CB-CME responsibilities are currently being provided by CalOptima's health networks. For HHP, CalOptima can leverage existing infrastructure to incorporate the new HHP services.

HHP focuses on a small percentage of CalOptima's overall membership. Based on the member distribution of HHP enrollment projections within the health networks, CalOptima staff's initial recommended approach was to provide health networks with an option of participating in HHP; however, this approach would potentially have required members to change their health networks and/or primary care providers when enrolling in HHP. In January 2019, DHCS advised that CalOptima must adhere to HHP expectation of not requiring members to change their health networks and/or primary care providers in order to participate in the HHP. Consequently, CalOptima will require all health networks, including CalOptima Direct and CalOptima Community Network, to participate in HHP and meet CB-CME requirements. This approach will provide an adequate CB-CME network and ensure continuity of members' relationships with their respective health networks and primary care providers.

Health Network Contracts
In order to implement HHP, CalOptima health network contracts will need to be amended, effective January 1, 2020, to include providing HHP services, expectations of CB-CME responsibilities, guidelines for information and data sharing, as well as HHP training. Prior to implementing HHP, CalOptima will coordinate with the health networks regarding the development of infrastructure, policies and procedures, reporting capabilities, staffing ratio requirements, and the ability to deliver core services with added intensity and new select services, where appropriate.

Amendment to County Behavioral Health MOU
Pursuant to DHCS All Plan Letter 18-015: Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans, MCPs participating in HHP must coordinate care for members enrolled in HHP who also receive care through the Mental Health Plan (MHP or County). The MOU with the Orange County Health Care Agency is the vehicle for ensuring this coordination. The Behavioral Health MOU between CalOptima and the County of Orange has been amended to reflect that CalOptima and the County agree to coordinate appropriate services for CalOptima members with mental health conditions who are enrolled in HHP.

Implementation Efforts
Based on DHCS feedback and in partnership with the health networks, CalOptima staff continues to develop and adjust operational procedures and polices outlining HHP requirements and operational processes impacting member engagement and enrollment, care management, CB-CME network and its responsibilities, staffing requirements and MCP oversight role. Currently, CalOptima's policies impacted by HHP requirements have been submitted to DHCS as part of the HHP regulatory submission requirements. Once CalOptima receives the feedback from DHCS, CalOptima staff will return to the Board with recommendations for approval of policy and procedures impacted by HHP requirements.

Additionally, CalOptima staff will continue to collaborate with Orange County HCA, Health Networks, and other stakeholders for Phase II of the Health Homes Program for SUD, SMI, and homelessness consistent with requirements as specified by DHCS.

Fiscal Impact
The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

Rationale for Recommendation
The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD and July 1, 2020, for members with SMI.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
3. Department of Health Care Services. Medi-Cal Health Homes Program, Program Guide 7/1/19
4. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 14

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

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

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM

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

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

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

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

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

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

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

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

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

Medi-Cal Health Homes Program
Program Guide
7/01/19

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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

a. Letter to member followed by phone call to member
b. Phone call to member, outreach to care delivery partners and social service partners
c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group	Counties	Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco	**P&Ps**:	3/1/18	5/1/18
		Network:	5/1/18	6/1/18
		SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino	**P&Ps**:	9/1/18	11/1/18
		Network:	11/1/18	12/1/18
		SMI MHP-MOU:	2/1/19	3/1/19
		SMI Network:	5/1/19	6/1/19
Group 3.1	Imperial Santa Clara	**P&Ps**:	1/1/19	5/1/19
		Network:	4/1/19	6/1/19
		SMI MHP-MOU:	7/1/19	8/1/19
		SMI Network:	10/1/19	12/1/19
Group 3.2	Alameda Kern Los Angeles Sacramento San Diego Tulare	**P&Ps**:	3/1/19	5/1/19
		Network:	5/1/19	6/1/19
		SMI MHP-MOU:	8/1/19	9/1/19
		SMI Network:	11/1/19	12/1/19
Group 4	Orange	**P&Ps**:	9/1/19	11/1/19
		Network:	11/1/19	12/1/19
		SMI MHP-MOU:	2/1/20	3/1/20
		SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

_____	_____
Managed Care Plan	Signature of Authorized Representative
_____	_____
Date	Name of Authorized Representative
	_____
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting	
***Note:* Only report one (1) exclusionary reason per member excluded from the Program.**	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred & enrolled (Column I)	Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure.
Number externally referred but excluded (Column J)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column K)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.
2. Health Home Program Member Activity Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Homeless/Housing Member Level Detail	
Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I.
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G)	Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No."
Received Housing Services During This Reporting Period (Column H)	Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No."
Homeless Health Homes Members In Any Enrollment Period (Column I)	Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."

HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J)	Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No."
4. Health Home Program Network Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.
5. Health Home Program Annual CMS Core Measures Reporting	

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator

CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator

CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CDF (MED) - Age 12-17 - numerator (Column W)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator
CDF (MED) - Age 12-17 - denominator (Column X)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator
CDF (MED) - Age 18-64 - numerator (Column Y)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator
CDF (MED) - Age 18-64 - denominator (Column Z)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator
CDF (MED) - Age 65+ - numerator (Column AA)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator
CDF (MED) - Age 65+ - denominator (Column AB)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator
CDF (SMI) - Age 12-17 - numerator (Column AC)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator
CDF (SMI) - Age 12-17 - denominator (Column AD)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator
CDF (SMI) - Age 18-64 - numerator (Column AE)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator
CDF (SMI) - Age 18-64 - denominator (Column AF)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator
CDF (SMI) - Age 65+ - numerator (Column AG)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator
CDF (SMI) - Age 65+ - denominator (Column AH)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator
6. Health Home Program Reporting Comments	
Column Name	**Explanation**
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

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Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
F11.121, F11.122, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.920, F12.921, F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.121, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.21, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.920, F19.921, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, T40.0X1A, T40.0X1D, T40.0X2A, T40.0X2D, T40.0X3A, T40.0X3D, T40.0X4A, T40.0X4D, T40.1X1A, T40.1X1D, T40.1X2A, T40.1X2D, T40.1X3A, T40.1X3D, T40.1X4A, T40.1X4D, T40.2X1A, T40.2X1D, T40.2X2A, T40.2X2D, T40.2X3A, T40.2X3D, T40.2X4A, T40.2X4D, T40.3X1A, T40.3X1D, T40.3X2A, T40.3X2D, T40.3X3A, T40.3X3D, T40.3X4A, T40.3X4D, T40.4X1A, T40.4X1D,

T40.4X2A, T40.4X2D, T40.4X3A, T40.4X3D, T40.4X4A, T40.4X4D, T40.601A, T40.601D, T40.602A, T40.602D, T40.603A, T40.603D, T40.604A, T40.604D, T40.691A, T40.691D, T40.692A, T40.692D, T40.693A, T40.693D, T40.694A, T40.694D
Kidney Disease
N18.1, N18.2, N18.3 , N18.4 , N18.5, N18.6, N18.9, Z48.22, Z49.01 , Z49.02, Z49.31 , Z49.32, Z91.15 , Z94.0

I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

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**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Ratification of Amendments to Medi-Cal Health Network Contracts, Excluding Those Involving the CHOC Physicians Network

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Ratify Medi-Cal health network contract amendments, excluding those involving the CHOC Physicians Network, to address continued payments to individual providers of Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services began in State Fiscal Year (SFY) 2018-19 and all future extensions thereafter provided the State of California continues the enhanced Proposition 56 payments to CalOptima.

Background/Discussion

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 either direct communication or 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 and rates are not provided until after the fiscal year begins; requiring MCPs to develop initial catch up and ongoing payment distribution processes.

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. On November 1, 2018 the Board authorized contract amendments to Medi-Cal health network contracts 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 had not been released as of May 8, 2019. Even though the final APL for the current fiscal year had not been released, DHCS instructed MCPs to distribute initial catch up SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019. In a separate Board action, CalOptima staff requested approval of a standardized annual Proposition 56 provider payment process.

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The standardized annual Proposition 56 provider payment process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. To continue Proposition 56 provider payments, Staff amended health network contracts to the extend the dates of service eligible for Proposition 56 payments into the current SFY and to ensure payments are made within with the timeframes based on DHCS guidance. CalOptima staff will seek subsequent Board action for further action if any future DHCS Proposition 56 requirements warrant significant changes to the standardized annual process.

Fiscal Impact

The recommended action to ratify amendments to Medi-Cal health network contracts, excluding those involving the CHOC Physicians Network, related to Proposition 56 is projected to be budget neutral to CalOptima. While total disbursement of Proposition 56 funding is dependent upon timely and accurate claims submissions from eligible providers, DHCS has projected Fiscal Year 2018-19 funding at approximately $102 million. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount, 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

Attachments

1. Conflicts of Interest List: Medi-Cal Health Networks
2. June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment
3. November 1, 2018 CalOptima Board Action Agenda Referral Report Item 10. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to Provider Health Network Contracts Except Those Pertaining to the CalOptima Community Network Contracts

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

6/20/2019 — **Date**

Conflicts of Interest List: Medi-Cal Health Networks

Name	Address	City	State	Zip Code
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CHOC Health Alliance	1120 West La Veta Ave., #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Action

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

Background/Discussion

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 SFY 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) were required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19. The proposed SFY 2018-19 extension included new reimbursement rates and eligible procedure codes.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. Proposition 56 provider payments apply to certain 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 delegated health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology for the disbursement of Proposition 56 payments with the understanding that the same process would be utilized should provisions under Proposition 56 be extended past SFY 2017-18. Additionally, on June

7, 2018, the CalOptima Board of Directors approved health network and physician contract amendments to effectuate Proposition 56 payments.

On September 25, 2018 DHCS verbally instructed Medi-Cal Managed Care Plans to continue paying the established SFY 2017-18 Proposition 56 criteria, rates, and procedure codes for services rendered in SFY 2018-19 until DHCS finalizes the SFY 2018-19 Proposition 56 requirements. On September 26, 2018, DHCS confirmed this guidance in writing. To continue Proposition 56 provider payments, health network contracts need to be amended to extend the dates of service eligible for Proposition 56 payments into SFY 2018-19. CalOptima staff will seek subsequent Board action once SFY 2018-19 Proposition 56 criteria, rates, and procedure codes are finalized and communicated by DHCS.

Fiscal Impact

The recommended action to enter into contract amendments with Medi-Cal health networks to continue Proposition 56 provider payments to eligible providers in SFY 2018-19 and for future periods, if enacted with appropriate funding levels, is expected to be budget neutral to CalOptima. CalOptima received initial funding of $4.26 per member per month (PMPM) for SFY 2017-18 Proposition 56 payments in the monthly capitation payment from DHCS beginning on April 30, 2018. Since then, DHCS has included Proposition 56 funding in subsequent capitation payments.

Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments in SFY 2018-19. However, since Proposition 56 funding will not be subject to a retrospective reconciliation, plans will be at risk for any expenses that exceed revenue. 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 complaint with Proposition 56 requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *10/24/2018*

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:

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**

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, Ste. 800	Orange	CA	92868
CHOC Physicians Network	1120 West La Veta Avenue, Suite 450	Orange	CA	92868
Children's Hospital of Orange County	1120 West La Veta Avenue, Suite 450	Orange	CA	92868
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
Family Choice Medical Group, Inc.	15821 Ventura Blvd., Suite 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 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 East Walnut Street, 2nd Floor	Pasadena	CA	91188
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	P.O. Box 6300	Cypress	CA	90630
United Care Medical Group, Inc.	600 City Parkway West, Ste. 400	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Authorizing Amended and Restated Medi-Cal Health Network Contract for Kaiser Foundation 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 an Amended and Restated Health Network Contract with Kaiser Foundation Health Plan, Inc., effective June 30, 2019 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; and
b) Amended capitation rates for assigned members effective July 1, 2019.

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: emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

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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.

The anticipated Medi-Cal revenue for FY 2019-20 is projected to be sufficient to cover the costs of the recommended action to amend capitation rates for assigned members effective July 1, 2019. Management has included projected expenses associated with the extended contracts in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval.

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 — *5/29/2019*

Authorized Signature — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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

CalOptima
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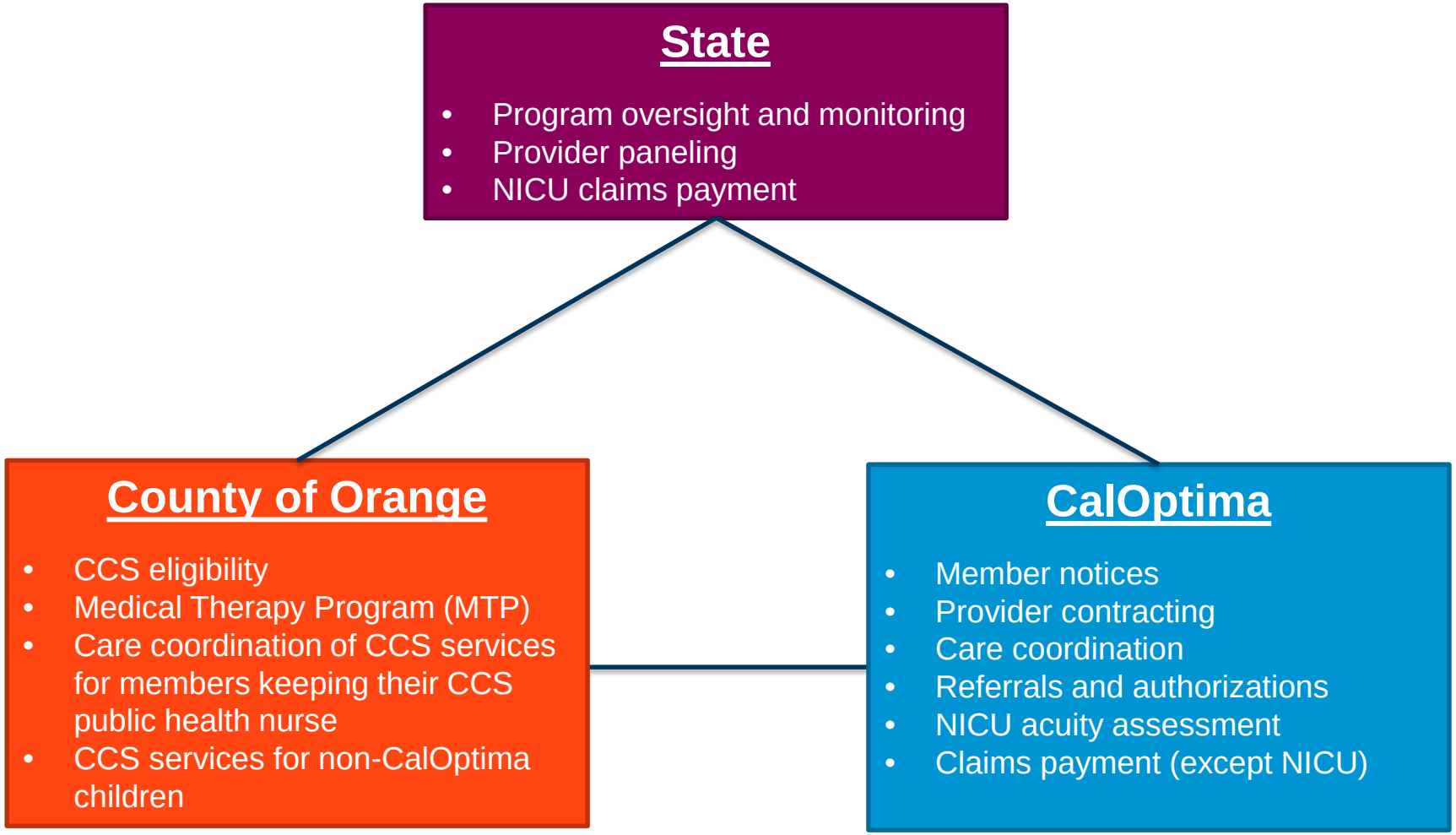
Background

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
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent

City of Residence (Top 5)
• 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

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
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Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

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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
_____ Name of Evaluator	Total Points Awarded	_____

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature _____ **Date** _____

Print Name _____

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Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

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

CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

17. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Provider Network Operations, (657) 900-1116
Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8887

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to remove Medi-Cal PBM services under the contract effective on the date that the Department of Healthcare Services (DHCS) takes over Medi-Cal Managed Care pharmacy benefits, which is expected to be no earlier than April 1, 2021.

Background

As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of a network of contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

Previously, the DHCS announced that it would be "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans (MCPs) and moving it to a fee-for-service program administered at the state level effective January 1, 2021. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. However, on November 16, 2020, DHCS informed MCPs that the implementation date for Medi-Cal Rx would be postponed until April 1, 2021. It is possible that DHCS will extend this implementation deadline in the future.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year term expired on December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. Rather than exercising the second one-year extension option, the parties agreed to a two-year extension, and at the Board's August 1, 2019 meeting, it approved the two-year extension, effective January 1, 2020 through December 31, 2021.

At its October 1, 2020 meeting, the CalOptima Board of Directors authorized an amendment to the agreement with MedImpact to extend the contract for provision of services for the OneCare, OneCare

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Connect and PACE lines of business through December 31, 2024 and to remove the Medi-Cal line of business effective January 1, 2021.

Discussion

Due to the postponement of Medi-Cal Rx, staff are recommending amending CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to remove the Medi-Cal line of business no sooner than April 1, 2021, and to be updated as needed if additional postponements are announced by DHCS.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Consolidated Operating Budget approved by the Board on June 4, 2020, included funding for PBM fees through the end of the fiscal year for the OneCare, OneCare Connect and PACE lines of business.

The FY 2020-21 Consolidated Operating Budget assumed the removal of the Medi-Cal line of business effective January 1, 2021. The fiscal impact to continue administering the pharmacy benefit for the three (3) month period of January through March 2021 results in an expected increase to pharmacy expenses of approximately $151,920,000 (currently unbudgeted), which is comprised of approximately $151 million in pharmacy reimbursement expenses and approximately $920,000 in PBM administrative expenses. Assuming DHCS continues to provide revenue similar to current levels, Staff anticipates such revenue will be sufficient to cover the expenses related to the extension period. In the event that DHCS further extends the Medi-Cal Rx implementation timeline, our working assumption is that it will continue to fund the program at similar levels. Staff will keep the Board apprised of any changes to these assumptions.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for the Medi-Cal line of business through March 31, 2021, and to be revised as needed if additional postponements are announced by DHCS.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract
5. Board Action dated August 6, 2020; Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration
6. Board Action dated October 1, 2020; Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend and Amend the Contract to Remove the Medi-Cal Line of Business
7. DHCS email notification dated November 16, 2020: Medi-Cal Rx Lengthens Transition Time to Full Implementation

/s/ Richard Sanchez — *11/24/2020*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

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

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

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

9/26/2018 — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
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Provider Network Management	75
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Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
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Catamaran	1,069
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Navitus	1,056
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Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract and Remove the Medi-Cal Line of Business

Contacts

Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to:

1. Remove the Medi-Cal (MC) line of business effective January 1, 2021; and

2. Extend the contract for provision of services for the OneCare, OneCare Connect and PACE lines of business through December 31, 2024.

Background

As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of a network of contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

Effective January 1, 2021, the Department of Health Care Service (DHCS) is "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to a fee-for-service program administered at the state level. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. Therefore, effective January 1, 2021, MedImpact services will include administering pharmacy benefits for CalOptima's OneCare, OneCare Connect and PACE programs only.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year term expired on December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. Rather than exercising the second one year extension option, the parties agreed to a two year extension, and at the Board's August 1, 2019 meeting, it approved the two year extension, effective January 1, 2020 through December 31, 2021.

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Discussion

Because of the complexity of the process and range of services provided, management estimates that a full replacement of CalOptima's PBM system would take over one year to complete, including the RFP process. It would require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives, and the process would need to begin by February 2021 at the latest. Furthermore, with the new Medi-Cal Rx program starting January 1, 2021, pursuing a PBM RFP with a potential PBM transition would cause significant disruptions for CalOptima providers.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.0 stars for 2020.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts annual audits of MedImpact. The purpose of the annual audits is to monitor PBM performance and ensure that CalOptima's pharmacy related obligations are being met satisfactorily for the Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC, CMS and DHCS regulatory requirements. CalOptima's annual audits of the PBM are comprised of two components: offsite and onsite. The offsite portion is performed as a desk review and the onsite portion takes place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate identified deficiencies.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for three years, through December 31, 2024 for the lines of business where CalOptima is responsible for ensuring that members have access to pharmacy services. Staff also recommends, in conjunction with the transfer of Medi-Cal pharmacy benefit management services to the state, to amend the contract to remove the Medi-Cal line of business since this function is being carved out by the state effective January 1, 2021. Staff have worked with MedImpact to develop a transition plan to ensure administrative obligations are met for the Medi-Cal Rx program requirements.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Consolidated Operating Budget approved by the Board on June 4, 2020 includes funding for pharmacy benefit management fees through the end of the fiscal year for the OneCare, OneCare Connect and PACE lines of business. The budget assumes the removal of the Medi-Cal line of business effective January 1, 2021. The recommended action to extend the MedImpact contract through December 31, 2024 is not expected to have any additional fiscal impact in the current fiscal year. Administrative fees paid to MedImpact for the OneCare, OneCare Connect and PACE lines of business will remain the same. Management plans to include funding for pharmacy benefit management fees for the remaining lines of business for the period of July 1, 2022, through December 31, 2024, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional three years, for the period of July 1, 2022, through December 31, 2024 with the elimination of the Medi-Cal line of business based on the DHCS's decision to transition to the Medi-Cal Rx model administered at the state level.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract
5. Board Action dated August 6, 2020; Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — *9/26/2018*

Authorized Signature — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

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

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

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Navitus	1,056
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Envision	980
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Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — *9/26/2018*

Authorized Signature — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

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

From:	Roady, TC
To:	Wood, Michael
Cc:	Frias, Patricia; Gericke, Kristin Pharm.D.
Subject:	FW: DHCS" Nov. 16 Communication to MCP CEOs Regarding Medi-Cal Rx Implementation Delay
Date:	Tuesday, November 17, 2020 10:21:00 AM
Attachments:	image001.png
Importance:	High

FYI, more detailed comm from DHCS to Plan CEOs below on Rx delay

From: Amber Kemp <akemp@calhealthplans.org>
Sent: Tuesday, November 17, 2020 10:06 AM
Subject: DHCS' Nov. 16 Communication to MCP CEOs Regarding Medi-Cal Rx Implementation Delay
Importance: High

CAHP State Programs Committee (Primary) and Pharmacy Directors:

Please see DHCS' notice below to MCP CEOs related to the Medi-Cal Rx implementation delay.

Thank you,

Amber

Amber Kemp, MBA
Vice President, State Medicaid Policy
California Association of Health Plans
1415 L Street, Suite 850
Sacramento, CA 95814

akemp@calhealthplans.org
Cell: (916) 802-4069
www.calhealthplans.org

From: MMCDPMB (MMCD)@DHCS <MMCDPMB@dhcs.ca.gov>
Sent: Monday, November 16, 2020 3:52 PM
To: scoffin@alamedaalliance.org; Barsam.kasravi@anthem.com; kristen.cerf@blueshieldca.com; Abbie Totten <Abbie.A.Totten@healthnet.com>; richard.sanchez@caloptima.org; ghund@calvivahealth.org; bfreeman@cencalhealth.org; ssonnenshine@ccah-alliance.org; ndiaz@chgsd.com; Sharron.Mackey@cchealth.org; mtatar@goldchp.org; Abbie Totten

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<Abbie.A.Totten@healthnet.com>; MSchrader@hpsj.com; maya.altman@hpsm.org; mcnaughton-j@iehp.org; doug.hayward@khs-net.com; nathaniel.l.oubre@kp.org; kyle.a.murphy@kp.org; jbaackes@lacare.org; Kotal, John <John.Kotal@molinahealthcare.com>; egibboney@partnershiphp.org; PFrias@rchsd.org; jgrgurina@sfhp.org; ctomcala@scfhp.com; kevin_kandalaft@uhc.com; Donna.stidham@aidshealth.org; BrizendineL@aetna.com
Cc: MMCDPMB (MMCD)@DHCS <MMCDPMB@dhcs.ca.gov>; Davis, Kirk@DHCS <Kirk.Davis@dhcs.ca.gov>; Boylan, Autumn@DHCS <Autumn.Boylan@dhcs.ca.gov>; Nau, Nathan@DHCS <Nathan.Nau@dhcs.ca.gov>; Vasquez, Michele@DHCS <Michele.Vasquez@dhcs.ca.gov>; Conde, Stephanie@DHCS <Stephanie.Conde@dhcs.ca.gov>; Tran, Tuyen@DHCS <Tuyen.Tran@dhcs.ca.gov>; Gutierrez, Alex@DHCS <Alex.Gutierrez@dhcs.ca.gov>; Scott, Jennifer@DHCS <Jennifer.Scott@dhcs.ca.gov>; Dutra, Michael@DHCS <Michael.Dutra@dhcs.ca.gov>; Cisneros, Bambi@DHCS <Bambi.Cisneros@dhcs.ca.gov>; Durham, Dana@DHCS <Dana.Durham@dhcs.ca.gov>; Bonnifield, Erica@DHCS <Erica.Bonnifield@dhcs.ca.gov>; Hendrix, Harry@DHCS <Harry.Hendrix@dhcs.ca.gov>
Subject: Medi-Cal Rx Lengthens Transition Time to Full Implementation

Hello Medi-Cal Managed Care Plan (MCP) Partners,

Given the ongoing challenges and constantly evolving health care landscape associated with the unprecedented COVID-19 public health emergency (PHE), the Department of Health Care Services (DHCS), after careful consideration and in close partnership and collaboration with Magellan Medicaid Administration, Inc. (Magellan), has decided to lengthen the transition time for full implementation of Medi-Cal Rx by three (3) months. DHCS and Magellan will continue to dedicate their combined efforts towards Assumption of Operations (AOO) for Medi-Cal Rx on April 1, 2021. In the interim, all current processes and protocols, both effectuated by DHCS and our Medi-Cal managed care plans (MCPs), respectively, should remain unchanged and in place until Medi-Cal Rx launches.

While neither DHCS nor Magellan takes this decision lightly, we are confident that given the COVID-19 PHE, this decision is in the best interests of our Medi-Cal beneficiaries and providers. Lengthening the full implementation will help to ensure a smoother and more complete transition, as well as mitigate potential disruptions to beneficiaries in accessing their medication. Moving the launch of Medi-Cal Rx to April 1, 2021, will provide additional and valuable opportunities for Medi-Cal providers, beneficiaries, MCPs, and other interested parties to become better acclimated to, and familiar with new Medi-Cal Rx policies and processes, through both additional messaging from DHCS and Magellan, as well as additional, targeted stakeholder engagement and outreach efforts.

Please note that DHCS will be updating the Medi-Cal beneficiary notice templates that were planned for release to Medi-Cal fee-for-service beneficiaries on or about December 1, 2020, to include information about the shift in the AOO for Medi-Cal Rx to April 1, 2021. Since our MCP partners are also doing a corresponding 30-day notice to their respective members, DHCS requests that you do not release those notices until you have changed the AOO date to April 1, 2021. Along the same lines, DHCS requests that you modify any outreach campaign materials to also reflect this date change, inclusive of any new Member Identification Cards, Member Handbook/Evidence of Coverage (Errata) changes, etc. Since the shift from AOO on January 1, 2020 to April 1, 2020, is the

only change being made at this time, MCPs do not need to resubmit these materials to DHCS for review and re-approval.

DHCS appreciates your continued support and collaboration relative to this important project, and looks forward to the successful launch and AOO of Medi-Cal Rx on April 1, 2021. If you have any questions about this notification or how it may impact your individual MCP, please feel free to reach out to your DHCS Contract Manager, or direct specific inquiries to the Medi-Cal Rx Project Team at RxCarveOut@dhcs.ca.gov. Thank you.

Sincerely,

The Department of Health Care Services
Medi-Cal Rx Project Team

Department of Health Care Services
MMCDPMB@dhcs.ca.gov | www.dhcs.ca.gov

Continued to a Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

18. Consider Authorizing Amendments to the Medi-Cal Shared-Risk Physician Group, Physician Hospital Consortium, and Health Maintenance Organization Health Network Contracts, Except Kaiser Foundation Health Plan, Inc.

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Health Network contracts for Medi-Cal Shared-Risk Physician Group (SRG), Physician Hospital Consortium (PHC), and Health Maintenance Organization (HMO) Health Networks, except Kaiser Foundation Health Plan, Inc., to:

1. Revise Whole Child Model (WCM) capitation rates;
2. Extend funding and revise reimbursement rates for Health Homes Program (HHP); and
3. Incorporate language changes including operational requirements.

Background/Discussion

CalOptima is currently contracted with twelve (12) separate Medi-Cal (MC) SRG, PHC, and HMO health network capitated and delegated entities. MC health network contracts renew on an annual basis, pending Board approval, each June. As needed, amendments are required to remain compliant with regulatory directives as well as CalOptima's internal policies and procedures and other changes.

Whole Child Model capitation rates:
CalOptima has received the DHCS updated reimbursement calculations for the WCM Program and based on the State funding, CalOptima is in a position to increase the capitation to the Health Networks.

Extension and funding for the Health Homes Program:
DHCS has extended HHP. Due to Coronavirus, this program has not realized the projected membership, and as such DHCS has increased funding for 2021. The Amendment will extend the program and rates to the Health Networks.

Operational requirements:
The Amendment will incorporate language changes including operational requirements such as: (i) increasing the notice requirement from 120 days to 180 days for termination for convenience, which allows a more appropriate timeframe for transition of members and related activities, including operational system changes; (ii) updating the Division of Financial Responsibility (DOFR); and (iii) contract language revisions, as appropriate, to align all Health Network contracts, such as the removal of the Member Liaison Program requirements which has been superseded by the Personal Care Coordinator (PCC) Program, requiring policies and procedures addressing offshore subcontracts related to Protected Health Information (PHI) and annual offshore attestation rather than CalOptima's prior approval of such subcontracts, clarifying regulatory requirements, and addressing legacy language.

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Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020, incorporated MC Health Network capitation expenses of nearly $1.2 billion, including updated Hospital capitation rates and its associated impact to Shared Risk Pool funding.

The recommended action to revise the WCM base capitation rates results in an estimated increase of approximately 7.1% or $55.36 per member per month. The increase in capitation is due to changes in anticipated expenses for delegated services. The estimated annual impact is $7.2 million. Additional funding from DHCS is anticipated to be sufficient to cover the additional WCM expense.

The recommended action to extend funding and revise reimbursement for the HHP core services capitation rate results in an estimated increase of approximately 22% or $130 per enrolled member per month. Extending funding and revising reimbursement for the HHP engagement services rate results in an estimated increase of approximately 3% or $0.52 per engaged member per month. These increases were primarily driven by the change in member distribution between Serious Mental Illness (SMI) and Chronic Condition (CC), as well as an additional Coronavirus adjustment to account for slower member ramp up and higher average acuity than anticipated. The estimated annual impact is $1.2 million. Additional funding from DHCS is anticipated to be sufficient to cover the additional HHP expense.

The recommended action to amend the MC Health Network contracts to revise contract language is budget neutral. Contract language revisions as described above are operational in nature with no additional fiscal impact beyond what was incorporated in the CalOptima FY 2020-21 Operating Budget.

The proposed changes to clarify the DOFR are not anticipated to have a material impact to MC Health Network capitation or CalOptima financials.

Rationale for Recommendation

Authorization for execution of the Amendments will ensure MC Health Networks and their providers aligned with current operational procedures.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

19. Consider Approval of Modification to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director Network Operations (657) 900-1116

Recommended Actions

Approve modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting [Medi-Cal, OneCare, OneCare Connect].

Background

CalOptima is obligated to comply with Department of Health Care Services (DHCS) contractual provisions and All Plan Letter (APL) guidance implementing federal Medicaid regulatory requirements for the submission of extensive data and reports (e.g. encounter data and Medical Loss Ratio (MLR) data). Management is required to attest to DHCS that the submitted data, information, and documentation is accurate, complete, and truthful, and CalOptima continues to experience increased regulatory scrutiny regarding delegation oversight of Subcontractors. All of CalOptima's contracted Health Networks are subject to CalOptima's Reporting Policy and have responsibilities as delegated entities that include complete, accurate, reasonable, and timely submissions to CalOptima.

Policy HH.2003 provides guidance on the submission and evaluation of more than 70 types of reports impacting all operational areas that Health Networks or Delegated Entities are required to submit to CalOptima. The policy, first made effective in 1998, impacts Medi-Cal, OneCare, and OneCare Connect, and is aligned with DHCS and Centers for Medicare & Medicaid (CMS) requirements. Policy HH.2003 requires that each Health Network or Delegated Entity submit these reports to CalOptima, as required by CalOptima and specified in its contract with CalOptima, the Timely and Appropriate Submission Grid (Report Grid), and/or CalOptima's policies and procedures.

Discussion

Proposed policy modifications include the addition of language detailing requirements surrounding the Report Binder, Report Grid and Report Grid Supplement attachments, and Attestation from Health Networks and Delegated Entities. The proposed language is intended to clearly delineate regulatory, contractual and policy citations underlying reports required from Health Networks and Delegated Entities.

The new policy attachments (i.e., the Report Grid and Report Grid Supplement) are intended to provide additional information and resources for staff, Health Networks and Delegated Entities in meeting the specified reporting requirements. The Report Grid is a matrix of the reports required by CalOptima, including report names, descriptions, operational ownerships, naming conventions, frequencies, submission methods and file formats. The Report Grid Supplement is a supplemental document to the Report Grid that includes detailed report descriptions, data elements and contractual, policy and

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regulatory citations for all required reports. For Medi-Cal, the updated version of the Report Grid, including Report Grid Supplement, requires Health Networks to submit a completed and signed Data Certification Statement on the Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful.

In line with the above, additional proposed modifications to the policy include new verbiage outlining contents of the Report Binder, in which CalOptima compiles and furnishes the updated Report Grid, Report Grid Supplement, Report Templates and Letter Templates for the Health Networks, and Delegated Entities. Also, staff proposed to add additional language to the Procedure section of Policy HH.2003, outlining the attestation process, whereby Health Networks and Delegated Entities are asked to complete and submit an attestation to CalOptima upon receipt of an updated Report Binder, Report Grid and/or Report Grid Supplement. This is required within five (5) business days, verifying receipt and implementation of the updated Report Binder.

Staff recommends that the Board approve the proposed updates to Policy HH.2003 in order to provide additional clarity and transparency regarding reports required from Heath Networks and Delegated Entities. The updated policy and its attachments are intended to help maintain accountability across CalOptima departments in requesting and updating reporting requirements for Health Networks and Delegated Entities. These updates will additionally serve as support for Health Networks and Delegated Entities in identifying applicable regulatory, statutory, and policy requirements.

Fiscal Impact
The recommended action to approve revisions to CalOptima Policy HH.2003 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
Updates to the policy will add clarity on the policy verbiage, as well as regulatory, contractual and policy citations driving required reporting by Health Networks and Delegated Entities.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Policy HH.2003: Health Network and Delegated Entity Reporting (Redlined and Clean versions), which includes:
    - Timely and Appropriate Submission Grid ("Report Grid")_
    - Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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Policy:	HH.2003
Title:	**Health Network and Delegated Entity Reporting**
Department:	Network Operations
Section:	Health Network Relations
CEO Approval:	
Effective Date:	10/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for submission and evaluation of reports that a Health Network or Delegated Entity is required to submit to CalOptima.

II. POLICY

A. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima, as required by CalOptima or as specified in its contract, the Report Binder~~,~~ (including but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

B. The Report Grid and Report Grid Supplement are distributed to Health Networks and Delegated Entities in the Report Binder.

C. The Report Binder shall contain the following:

1. Report Grid;

2. Report Grid Supplement;

3. Report Templates; and

4. Letter Templates.

~~B.~~D. Each responsible CalOptima department shall be accountable for:

1. Identifying required reports;

   a. Reports must list all applicable regulatory, contractual, and policy citations and include all required data elements.

2. Creating and maintaining the Table of Authorities for each report;

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~~2.~~3. Creating templates and all applicable reporting ~~format and~~formats, instructions~~;~~, and technical guidelines;

~~3.~~4. Monitoring submission and timeliness of reports;

~~4.~~5. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

~~5.~~6. Notifying Health Network Relations of unsuccessful follow-up attempts; and

~~6.~~7. Escalating issues of continued noncompliance to the Office of Compliance.

~~C.~~E. CalOptima's Health Network Relations Department shall be responsible for:

1. Maintaining and updating the Report Binder, in consultation with CalOptima departments and the Office of Compliance;

2. Distributing the Report Binder to Health Networks and Delegated Entities ~~on an annual basis~~quarterly, or more frequently if needed; and

3. Contacting Health Networks and Delegated Entities if a CalOptima department is not successful with its follow-up attempts.

~~D.~~F. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

III. PROCEDURE

A. Identification of Reporting Requirements

1. Each responsible CalOptima department shall, ~~annually, or as necessary~~on an ongoing basis:

   a. Monitor regulatory, statutory, and/or contract requirements to determine impact on Health Network or Delegated Entity reporting requirements; and

   b. With the assistance of the Office of Compliance, review the Report Binder to:

      i. Update or correct existing reports;

      ii. Identify new reports~~;~~ and associated regulatory, contractual, and policy citations to support new reports;

      ~~iii. Eliminate duplicate or overlapping data requests;~~

      ~~iv.~~iii. Update or create Report Grid requirements, Report Templates, Table of Authorities, data dictionary, data elements, and/or instructions; and

      ~~v.~~iv. Notify the Health Network Relations Department of changes to the Report Binder.

B. Distribution of Report Binder

~~2.~~1. The Health Network Relations Department shall, ~~annually~~quarterly, and as necessary:

a. Distribute the Report Binder to departments to review Health Network or Delegated Entity reporting requirements~~, as described~~;

i. ~~Compile all~~CalOptima departments shall have ten (10) business days to review the Report Binder and submit changes or updates to the Health Network Relations Department.

b. Collect updates to Report Grid requirements, Report Templates, data dictionaries, ~~and/or~~ Tables of Authorities, Report Grid Supplement, and instructions to compile into the Report Binder, as submitted by departments; ~~and~~

c. Review department updates for completeness and eliminate duplicate or overlapping reports, with consultation from the responsible CalOptima department; and

~~c.~~d. Distribute the Report Binder to Health Networks and Delegated Entities on the first (1st) business day of each calendar quarter.

i. CalOptima's Health Network Relations Department shall provide Health Networks and Delegated Entities with an attestation to complete upon distribution of the updated Report Binder.

ii. Health Networks and Delegated Entities shall submit the signed attestation to the CalOptima Health Network Relations Department within five (5) business days, acknowledging receipt of the updated Report Binder.

~~B.~~C. Reporting Procedures

1. A Health Network or Delegated Entity shall submit reports in the time, manner, and file format specified by CalOptima or identified in its contract, the Report Binder~~,~~ (including, but not limited to, the Report Grid and~~/~~ the Report Grid Supplement), or CalOptima's policies and procedures.

2. If a Health Network or Delegated Entity report contains Protected Health Information (PHI), the Health Network or Delegated Entity shall submit the report to CalOptima via:

   a. CalOptima's secure FTP site; or

   b. Secure electronic mail, as specified by the specific report instructions.

3. Each responsible department shall:

   a. Monitor or audit, as applicable, a Health Network or Delegated Entity's submission of required reports and compliance with requirements of the Health Network contract, the Report Binder~~,~~ and CalOptima's policies and procedures;

   b. Make two (2) documented attempts to contact the Health Network or Delegated Entity to address missing, incorrect, or late submission;

   c. Notify Health Network Relations Department if a Health Network or Delegated Entity does not respond after two (2) follow-up attempts; and

   d. Report continued noncompliance to the Office of Compliance.

4. The Health Network Relations Department, upon receipt of notification from the responsible department of unsuccessful attempts to contact the Health Network or Delegated Entity, shall:

   a. Contact the Health Network or Delegated Entity to obtain the missing report(s) and, if necessary, escalate the issue to the Health Network's senior management; and

   b. Work with the department and Health Network or Delegated Entity to correct any content, formatting, or submission issues, if applicable.

5. The Office of Compliance, upon receipt of notification from the responsible department of a Health Network or Delegated Entity's continued noncompliance, shall take appropriate action in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

IV. ATTACHMENT(S)

~~Not Applicable~~
A. Timely and Appropriate Submission Grid ("Report Grid")
B. Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C.~~A. ~~CalOptima Health Network Service Agreement~~
~~D.~~A. ~~CalOptima Policy HH.2002Δ: Sanctions~~
~~E.~~A. ~~CalOptima Policy HH.2005Δ: Corrective Action Plan~~
~~F.~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Policy HH.2005Δ: Corrective Action Plan
G. Standard Reporting Requirements Matrix

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/29/2016	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/1999	HH.2003	Health Network Reporting	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2002	HH.2003	Health Network Reporting	Medi-Cal
Revised	07/01/2004	HH.2003	Health Network Reporting	Medi-Cal
Revised	01/01/2007	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/2015	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	09/01/2016	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	11/01/2018	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	05/01/2019	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	TBD	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Delegated Entity	For purposes of this policy, a delegated entity is contracted with CalOptima to provide dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Members.
Health Network	For purposes of this policy, a Physician-Hospital Consortia (PHC), Physician Medical Group (PMG), or a Shared Risk Group (SRG) 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.
Letter Templates	For the purposes of this policy, regulatory letter templates issued by regulatory agencies to be used by Health Networks and Delegated Entities for member communications, as required by applicable contractual, policy, and regulatory requirements.
Report Template	A blank form of each report also including instructions and file layout and/or data dictionary.
Sanction	Action taken by CalOptima including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a delegate's, subcontractor's, or any Capitated Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima programs.
Table of Authorities	For the purposes of this policy, a document that outlines all applicable regulatory, contractual, and policy citations that support the required reports outlined in the Report Grid.
Timely and Appropriate Submission Binder ("Report Binder")	A soft copy document that identifies all reports required of Health Networks to meet CalOptima's operational and regulatory compliance; contains the Report Grid and Report Templates, as well as a data certification statement.
Timely and Appropriate Submission Grid ("Report Grid")	A matrix of reports required by CalOptima, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats., as set forth in Attachment A of this Policy.
Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")	A supplemental document to the Report Grid that includes detailed report descriptions, data elements and citations for all required reports, as set forth in Attachment B of this Policy.

Policy:	HH.2003
Title:	**Health Network and Delegated Entity Reporting**
Department:	Network Operations
Section:	Health Network Relations
CEO Approval:	
Effective Date:	10/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for submission and evaluation of reports that a Health Network or Delegated Entity is required to submit to CalOptima.

II. POLICY

A. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima, as required by CalOptima or as specified in its contract, the Report Binder (including but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

B. The Report Grid and Report Grid Supplement are distributed to Health Networks and Delegated Entities in the Report Binder.

C. The Report Binder shall contain the following:

1. Report Grid;
2. Report Grid Supplement;
3. Report Templates; and
4. Letter Templates.

D. Each responsible CalOptima department shall be accountable for:

1. Identifying required reports;
    a. Reports must list all applicable regulatory, contractual, and policy citations and include all required data elements.
2. Creating and maintaining the Table of Authorities for each report;
3. Creating templates and all applicable reporting formats, instructions, and technical guidelines;

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4. Monitoring submission and timeliness of reports;

5. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

6. Notifying Health Network Relations of unsuccessful follow-up attempts; and

7. Escalating issues of continued noncompliance to the Office of Compliance.

E. CalOptima's Health Network Relations Department shall be responsible for:

1. Maintaining and updating the Report Binder, in consultation with CalOptima departments and the Office of Compliance;

2. Distributing the Report Binder to Health Networks and Delegated Entities quarterly, or more frequently if needed; and

3. Contacting Health Networks and Delegated Entities if a CalOptima department is not successful with its follow-up attempts.

F. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

III. PROCEDURE

A. Identification of Reporting Requirements

1. Each responsible CalOptima department shall, on an ongoing basis:

a. Monitor regulatory, statutory, and/or contract requirements to determine impact on Health Network or Delegated Entity reporting requirements; and

b. With the assistance of the Office of Compliance, review the Report Binder to:

i. Update or correct existing reports;

ii. Identify new reports and associated regulatory, contractual, and policy citations to support new reports;

iii. Update or create Report Grid requirements, Report Templates, Table of Authorities, data dictionary, data elements, and/or instructions; and

iv. Notify the Health Network Relations Department of changes to the Report Binder.

B. Distribution of Report Binder

1. The Health Network Relations Department shall, quarterly, and as necessary:
a. Distribute the Report Binder to departments to review Health Network or Delegated Entity reporting requirements;

i. CalOptima departments shall have ten (10) business days to review the Report Binder and submit changes or updates to the Health Network Relations Department.

b. Collect updates to Report Grid requirements, Report Templates, data dictionaries, Tables of Authorities, Report Grid Supplement, and instructions to compile into the Report Binder, as submitted by departments;

c. Review department updates for completeness and eliminate duplicate or overlapping reports, with consultation from the responsible CalOptima department; and

d. Distribute the Report Binder to Health Networks and Delegated Entities on the first (1st) business day of each calendar quarter.

i. CalOptima's Health Network Relations Department shall provide Health Networks and Delegated Entities with an attestation to complete upon distribution of the updated Report Binder.

ii. Health Networks and Delegated Entities shall submit the signed attestation to the CalOptima Health Network Relations Department within five (5) business days, acknowledging receipt of the updated Report Binder.

C. Reporting Procedures

1. A Health Network or Delegated Entity shall submit reports in the time, manner, and file format specified by CalOptima or identified in its contract, the Report Binder (including, but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

2. If a Health Network or Delegated Entity report contains Protected Health Information (PHI), the Health Network or Delegated Entity shall submit the report to CalOptima via:

a. CalOptima's secure FTP site; or

b. Secure electronic mail, as specified by the specific report instructions.

3. Each responsible department shall:

a. Monitor or audit, as applicable, a Health Network or Delegated Entity's submission of required reports and compliance with requirements of the Health Network contract, the Report Binder and CalOptima's policies and procedures;

b. Make two (2) documented attempts to contact the Health Network or Delegated Entity to address missing, incorrect, or late submission;

c. Notify Health Network Relations Department if a Health Network or Delegated Entity does not respond after two (2) follow-up attempts; and

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IV. ATTACHMENT(S)

A. Timely and Appropriate Submission Grid ("Report Grid")
B. Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
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Date	Regulatory Agency
04/29/2016	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/1999	HH.2003	Health Network Reporting	Medi-Cal
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Revised	07/01/2004	HH.2003	Health Network Reporting	Medi-Cal
Revised	01/01/2007	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/2015	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	09/01/2016	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	HH.2003	Health Network Reporting	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
				OneCare OneCare Connect
Revised	11/01/2018	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	05/01/2019	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	TBD	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect

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Timely and Appropriate Submission Grid ("Report Grid")	A matrix of reports required by CalOptima, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats, as set forth in Attachment A of this Policy.
Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")	A supplemental document to the Report Grid that includes detailed report descriptions, data elements and citations for all required reports, as set forth in Attachment B of this Policy.

Timely and Appropriate Submission Grid - Master

Year: 2020, Release: 4, Release Date: 10/13/20									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements)	LINK TO TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Annual Audit	Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/Annual Audit	Audit and Oversight	**Annually; Per process**	1_AORPT_**HN_CAT**	HN = Health network # CAT = Audit Category	hn_reporting	Zip	x	x	x		x	x	x	
Claims XML Universe	Health Networks shall submit a complete Claims universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/XML Version 2.0/Claims	Audit and Oversight	**Monthly: 2nd of every month**	2_XMLRPT_**HN**_CLM_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x	x	x	
Claims Universe Case Files	Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/Claims, UM Universe Case Selections	Audit and Oversight	**Monthly: 10th of every month**	1_AORPT_**HN_MMYYYY**_CLAIMS_**LB**_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC =	hn_reporting	PDF	x	x	x	x	x	x	x	
Credentialing Monthly Universe	Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/Credentialing Universe	Audit and Oversight and Quality Improvement	**Health Networks and Kaiser Monthly: 2nd of every month VSP Quarterly: January 10, April 10, July 10, October 10**	2_AORPT_QIRPT_**HN_MMYYYY**_CRED	MM = 2 digit month	hn_reporting	Excel	x	x	x	x	x	x	x	
Credentialing Universe Monthly Case Files	Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/Credentialing Universe	Audit and Oversight	**Monthly: 10th of every month**	1_AORPT_**HN_MMYYYY**_CRED_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	PDF	x	x	x	x	x	x	x	
Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/NOMNC	Audit and Oversight	**Monthly: 2nd of every month**	1_AORPT_**HN_MMYYYY**_NOMNC_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Word		x	x	x			x	
NOMNC Files (OneCare & OneCare Connect)	Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/NOMNC	Audit and Oversight	**Monthly: 10th of every month**	1_AORPT_**HN_MMYYYY**_NOMNC_FILES_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF		x	x	x			x	
Provider Dispute Resolution (PDR) XML Universe	Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight	Audit and Oversight	**Monthly: 2nd of every month**	1_XMLRPT_**HN**_PDR_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x	x	x	
PDR Universe Case Files	Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML Universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/PDR Universe Case Selections	Audit and Oversight	**Monthly: 10th of every month**	1_AORPT_**HN_MMYYYY**_PDR_**LB**_FILES	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x	x	x	
Provider Directory Universe Case Files	Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/Provider Directory Universe	Audit and Oversight	**Annually, per request**	1_AORPT_**HN**_PD_**QTYYYY**	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF (zip)	x	x	x	x			x	
Utilization Management (UM) XML Universe	Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/XML Version 2.0/Authorizations	Audit and Oversight	**Monthly: 2nd of every month**	2_XMLRPT_**HN**_UM_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x		x	
UM Universe Case Files	Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/Claims, UM Universe Case Selections	Audit and Oversight	**Monthly: 10th of every month**	1_AORPT_**HN_MMYYYY_LB**_Files	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x		x	
Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser	Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Behavioral Health/	Behavioral Health	**Monthly: 15th of every month**	1_BHRPT_**HN**_CalOptima.CDE.**MM.YYYY**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	hn_reporting	Excel	x				x		x	

Timely and Appropriate Submission Grid - Master

Year: 2020, Release: 4, Release Date: 10/13/20									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements)	LINK TO TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	Kaiser shall submit the Medi-Cal Expansion (MCE) DHCS Report, containing mental health grievances and appeals data.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Behavioral Health/	Behavioral Health	**Quarterly; January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	x				x		x	
Case Management Log	Health Networks shall submit monthly Case Management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/Case Management Log	Case Management	**Monthly: 15th of every month**	1_CMRPT_**HN_MMYYYY**_CM	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x		x	x	x		x	
Continuity of Care (Whole-Child Model)	Health Networks shall submit weekly report of Continuity of Care (COC) for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/WCM Continuity of Care	Case Management	**Weekly; every Tuesday by 10 am for the prior week's activity**	1_WCMMC_**HN_YYYYMMDD**_COC	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x	x		x	
Enhanced Monitoring Report (WCM)	Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/WCM Enhanced Reporting	Case Management, Regulatory Affairs	**Quarterly; 5th day after the end of the quarter**	1_WCMMC_**HN_YYYYMMDD**_Enhanced.xlsx	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x	x		x	
Health Homes Program (HHP) Enrollment and Disenrollment Report	Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Information Systems	Case Management	**Monthly: 10th of every month**	**HN**_HHP_Enrollment.csv	HN = Health network reporting #	Managed_HN_Reporting/H HP/Inbound	Excel	x			x	x		x	
HHP Finalized Engagement List (FEL) Return File	Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Information Systems	Case Management	**Monthly: 10th of every month**	**HN**_HHP_ReturnFEL	HN = Health network reporting #	Managed_HN_Reporting/H HP/Inbound	Excel	x			x	x		x	
HHP Services	Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Information Systems	Case Management	**Monthly: 10th of every month**	1_HHPServices_**HN_YYYYMM**.csv	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Managed_HN_Reporting/H HP/Inbound	Excel	x			x	x		x	
Implementation Audit (OneCare Connect)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/Implementation Audit	Case Management	**Ongoing, per process**	**HN_Member CIN**_OCC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Implementation Audit (OneCare)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/Implementation Audit	Case Management	**Ongoing, per process**	**HN_Member CIN**_OC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OC/RevisedMOC/Inbound	PDF		x		x			x	
Implementation Audit (Seniors and Persons with Disabilities/SPD)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/Implementation Audit	Case Management	**Ongoing, per process**	**HN_Member CIN**_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	MediCal/RevisedMOC/Inb ound	PDF	x			x			x	
Organ Transplant - Kaiser	Kaiser shall submit monthly report of members engaged in the organ transplant process.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/Organ Transplants - Kaiser	Case Management	**Monthly: 15th of every month**	1_CMRPT_04_**MMYYYY**_OT	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Annual Redetermination Files	Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/Annual Redetermination Files	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_WCM_AR_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	WCM Revised MOC/Inbound	PDF	x			x	x		x	
Individual Care Plan/Health Action Plan (ICP/HAP) bundle	Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/	Case Management (MOC)	**Ongoing, per process**	HN#_CIN_HHP_MMDDYYYY	HN=Health network reporting #,CIN-, MM=2 digit month, DD-2 digit day, YYYY=4 digit year (MMDDYYY=date ICP/HAP completed)	HN#HNname/MediCal/HH P MOC/Inbound	PDF	x			x	x		x	
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirement for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF			x	x			x	

Timely and Appropriate Submission Grid - Master

Year: 2020, Release: 4, Release Date: 10/13/20									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements)	LINK TO TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/ICT Bundle	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	x						x	
ICT Bundle (OneCare)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/ICT Bundle	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBER CIN**_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OneCare/RevisedMOC/Inbound	PDF		x		x			x	
Long Term Care (LTC) ICP Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_LTC_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Pediatric ICT Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/ICT Bundle	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_PEDS_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	x			x			x	
Model of Care (MOC) SPD Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/MOC Tracking File	Case Management (MOC)	**Monthly: 6th of every month**	**HN**271**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	SPD Revised MOC/Inbound	Pipe delimited text file	x			x	x		x	
MOC Tracking Log (OneCare Connect)	Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/MOC Tracking File	Case Management (MOC)	**Monthly: 6th of every month**	**HN**871**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OCC/RevisedMOC/Inbound	Pipe delimited text file			x	x			x	
MOC Tracking Log (OneCare)	Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/MOC Tracking File	Case Management (MOC)	**Monthly: 6th of every month**	**HN**571**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OneCare/RevisedMOC/Inbound	Pipe delimited text file		x		x			x	
MOC WCM Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/MOC Tracking File	Case Management (MOC)	**Monthly: 6th of every month**	**HN**275**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	WCM Revised MOC/Inbound	Pipe delimited text file	x			x			x	
Network Staff Legend File	Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OCC only). This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/Network Staff Legend File	Case Management (MOC)	**Monthly: 6th of every month**	HN429**YYYYMMDD**	HN = Health network reporting # YYYY = 4 digit year MM = 2 digit month DD = 2 digit day	/RevisedMOC/Inbound	Pipe delimited text File	x	x	x	x			x	
WCM ICP Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 days of HRA completion.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/ICT Bundle	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_WCM_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	WCM Revised MOC/Inbound	PDF	x			x	x		x	
DHCS WCM Report - Kaiser	Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/DHCS WCM Report - Kaiser	Case Management, GARS, Utilization Management	**Monthly: 15th of every month** **First Submission: 10/15/19 (Jul, August, September 2019 data), monthly thereafter**	1_WCMMC_04_**YYYYMM**_DHCS	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	Managed_HN_Reporting/ WCM/Inbound	Excel	x				x		x	
Population Health Management Program Description - Kaiser	Kaiser shall develop a PHM program description and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management	Case Management and Population Health Management	**Annually: February 15**	2_CMRPT_DMRPT_04_Annual**YYYY**_CMPD	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x		x	
DHCS WCM Report	Health Networks shall submit monthly report of WCM authorizations and care coordination.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Case Management/DHCS WCM Report	Case Management, Utilization Management	**Monthly: 15th of every month** **First submission: 10/15/19 (Jul, Aug, Sep '19 data), monthly thereafter**	1_WCMMC_**HN_YYYYMM**_DHCS	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x			x	

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Year: 2020, Release: 4, Release Date: 10/13/20									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements)	LINK TO TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Claims Third Party Liability (TPL)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Claims Reporting/Claims Third Party Liability/	Claims	**Monthly: 30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	x				x		x	
Claims TPL (OneCare Connect)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Claims Reporting/Claims Third Party Liability (OneCare Connect)/	Claims	**Monthly: 30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL_DB	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF			x	x			x	
DHCS Post-Payment Recovery Report (Medi-Cal Only)	Health Networks shall submit monthly report of post payment recovery data for other health coverage (OHC) claims to CalOptima.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Claims Reporting	Claims	**Monthly: 3rd business day of every month**	1_MCPPR_XX_YYYYPP_SS	HN = Health network reporting # MM = 2 digit month YYYY = 4 digit year	hn_reporting	Text File	x			x	x		x	
Customer Service Call Log Universe	Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Customer Service	Customer Service	**Quarterly: January 7, April 7, July 7, October 7**	MC: 1_CSRPT_**HN**_CS_MC_**QQYYYY** OC: 1_CSRPT_**HN**_CS_OC_**QQYYYY** OCC: 1_CSRPT_**HN**_CS_OCC_**QQYYYY**	HN = Health network # QQ = 2 digit quarter (Q1, etc) YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x			x	
Health Network Dashboard	Health Networks shall submit report of call center statistics for monthly review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Customer Service	Customer Service	**Monthly: 15th of every month**	2_HMRPT_CSRPT_**HN_MMYYYY**_Dashboard	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
Interpreter Services Utilization Report	Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Customer Service	Customer Service	**Quarterly: January 30, April 30, July 30, October 30**	2_CSRPT_QIRPT_**HN_QTYYYY**_CCS_2019	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
DHCS NMT/NEMT Report - Kaiser	Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/GARS - Kaiser Only	Customer Service, GARS	**Monthly: 27th of every month**	2_CSRPT_GARSRPT_04_NMT-NEMT_**MMYYYY**	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Annual Audited Financial Statements	Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only).	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_AAFS	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
Incurred But Not Reported (IBNR) Documentation	Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
Medical Loss Ratio (MLR)	Health Networks shall submit interim and final reports of the Health Network MLR.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance	Finance	**Interim: January - June due August 15.** **Interim: January - December due February 15** **Final: Annual submission of all 12 months due June 30**	1_FINRPT_**HN_SemiAnnual YYYY**_MLR 1_FINRPT_**HN_AnnualYYYY**_MLR 1_FINRPT_**HN_FinalYYYY**_MLR	HN = Health network reporting # YYYY= 4 digit year	hn_reporting	Excel (using most current AFRF)	x		x	x			x	
Risk Bearing Organization (RBO) Report	Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only).	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance	Finance	**Annual submission due 150 days after the fiscal year ends.** **Quarterly: February 15, May 15, August 15, November 15**	1_FINRPT_**HN**_Annual**YYYY**_DMHC (Annual) 1_FINRPT_**HN_QTYYYY**_DMHC (Quarterly)	HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter #	hn_reporting	PDF or Excel	x	x	x	x			x	
Total Business Reports	Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance	Finance	**Quarterly: February 15, May 15, August 15, November 15**	1_FINRPT_**HN_QTYYYY**_TBFS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
DHCS Quarterly Report - Kaiser	Kaiser shall submit quarterly report of grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/GARS - Kaiser Only/GrievanceReportTemplate	GARS	**Quarterly: January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_DHCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
Grievances Volume Report Kaiser	Kaiser shall submit quarterly report of grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/GARS - Kaiser Only/Grievance Volume Report Template	GARS	**Quarterly: January 23, April 23, July 23, October 23**	1_GARSRPT_HMO04_QQYYYY_VOL	QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	

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Year: 2020, Release: 4, Release Date: 10/13/20									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements)	LINK TO TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Community-Based Adult Services (CBAS) Report - Kaiser	Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/GARS - Kaiser Only	GARS, Customer Service, Long Term Services and Supports	**Quarterly: January 23, April 23, July 23, October 23**	3_GARSRPT_CSRPT_LTSSRPT_HMO04_**QTYYYY**_CBAS	QT = 2 digit Quarter # YYYY = 4 digit year	Incoming	Text File	x				x		x	
DHCS Data Certification Statement	Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Audit & Oversight/Data Certification	HNR	**Monthly: 25th of every month**	1_AORPT_**HN**_Data Certification_**MMYYYY**	HN = Health network #	hn_reporting	PDF	x			x	x	x	x	
Health Network Newly Contracted Provider Training Report	Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/HNR	HNR	**Quarterly: January 25, April 25, July 25, October 25**	1_HMRPT_**HN_QTYYYY**_NCT	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
Primary Care Provider (PCP) Upload File	Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/HNR	HNR	**Bi-monthly: 10th and 25th of every month**	**HN**204**JJJ**	HN = Health network reporting # JJJ = Julian Date	hn_reporting	Excel	x			x			x	
DHCS Supplemental Data – Kaiser	Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/IS	IS	**Monthly; 15th of every month**	CalOptima_KSR_PRD_Supplementals_[yyyymm].txt	YYYY= 4 digit year MM = 2 digit month	Incoming	Text File	x				x		x	
Vision Service Plan (VSP) Provider Roster	VSP shall submit monthly report of VSP providers for the print and online provider directories.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/HNR	PDMS	**Monthly: 15th of every month**	VSP_Medicaid_CA_Orange_County_Provider_Listing_**YYYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day		Excel	x					x	x	
Health Education Calendar Kaiser	Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Population Health Management	Population Health Management	**Semi-Annually: January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HECALENDAR	HN = Health network reporting # MM = 2 digit month YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
Health Education Individual Encounters - Kaiser	Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Health Education-Disease Management - Kaiser Only	Population Health Management	**Semi-Annually January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEIE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	x				x		x	
Health Education Other Encounters - Kaiser	Kaiser is required to submit Health Education Other Encounters semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Health Education-Disease Management - Kaiser Only	Population Health Management	**Semi-Annually January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEOE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	x				x		x	
Perinatal Support Services (PSS) Encounters - Kaiser	Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Population Health Management	Population Health Management	**Monthly: 15th of every month**	1_DMRPT_04_**MMYYYY**_PSS_Services	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Access and Availability Report - Kaiser	Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Analytics	Quality Analytics	**Annually: February 15**	1_MDMRPT_04_Annual**YYYY**_Access	YYYY = 4 digit year	hn_reporting	Excel or Word or PDF	x				x		x	
Quality Improvement (QI) Evaluation (Previous Year) - Kaiser, VSP	Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15**	1_QIRPT_**HN**_Annual**YYYY**_QIE	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x	*	x	
QI Program - Kaiser, VSP	Kaiser shall develop an annual QI report and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15**	1_QIRPT_**HN**_Annual**YYYY**_QIP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x	*	x	
QI Work Plan - Kaiser, VSP	Kaiser shall report progress towards QI program goals semi-annually.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement	Quality Improvement	**Semi-Annually: February 15 and August 15**	1_QIRPT_**HN**_SemiAnnual**YYYY**_QI	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x				x	*	x	
QI Work Plan Current Year (Initial) - Kaiser, VSP	Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15 (for new year)**	1_QIRPT_**HN**_Annual**YYYY**_QICY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x				x	*	x	
Report of Findings and Actions Taken as a Result of QI Activities - Kaiser, VSP	Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement	Quality Improvement	**Quarterly**	1_QIRPT_**HN_QTYYYY**_QI Findings	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF	x				x	x	x	
Authorization Utilization Report	Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable). Unused authorization reporting shall include the claims status for each referral authorized during the measurement period.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Utilization Mgmt/Authorization Utilization	Utilization Management	**Quarterly: Q3 2019 - February 15, 2020 Q4 2019 - May 15, 2020 Q1 2020 - August 15, 2020 Q2 2020 - November 15, 2020**	1_QIRPT_**HN_QTYYYY**_AUTH	HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year	hn_reporting	Excel	x			x	x		x	

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Timely and Appropriate Submission Grid - Master

Year: 2020, Release: 4, Release Date: 10/13/20									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	**DESCRIPTION/REQUIREMENT (Refer to "Link to Template (Health Network)" for required reporting elements)**	**LINK TO TEMPLATE (HEALTH NETWORK)**	**CALOPTIMA DEPARTMENT**	**REPORT FREQUENCY**	**NAMING CONVENTION**	**NAMING CONVENTION INSTRUCTIONS**	**FTP FOLDER**	**FILE TYPE**	**MEDI-CAL**	**ONECARE**	**ONECARE CONNECT**	**Health Networks (Except Kaiser)**	**Kaiser**	**VSP**	**Oversight**	**Reimbursement**
Dental Anesthesia Report	Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD).	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Utilization Mgmt/Dental Anesthesia Report/	Utilization Management	**Quarterly: 15th of the month after the end of the quarter**	1_UMRPT_**HN_QTYYYY**_DA	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x			x			x	
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Utilization Mgmt	Utilization Management	**Annually: February 15**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UME	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x	x	x	x	x		x	
UM Program	Health Networks shall develop a UM program description and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Utilization Mgmt	Utilization Management	**Annually: February 15**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x	x	x	x	x		x	
UM Work Plan (ICE)	Health Networks shall report progress towards UM program goals semi-annually.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Utilization Mgmt	Utilization Management	**Semi-Annually: February 15 and August 15**	2_UMRPT_AORPT_**HN**_SemiAnnual**YYYY**_UMCY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
UM Work Plan Current Year (Initial)	Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Utilization Mgmt	Utilization Management	**Annually: February 15 (for new year)**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMCY	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
Out-of-Network (OON) Requests	Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Utilization Mgmt/Out of Network Requests/	Utilization Management	**Quarterly: January 25, April 25, July 25, October 25**	1_UMRPT_**HN_QTYYYY**_OON	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x			x	x		x	
Kaiser WCM Claim Detail	Kaiser shall submit monthly report of WCM claims payment information.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Claims Reporting	Claims	**Monthly: 15th of every month**	Kaiser_ClaimDetail_MMDDYY	DD = 2 digit day MM = 2 digit month YYYY = 4 digit year	incoming	Excel	x				x			x
Preclusion List Report for Member Notifications Only	Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima Customer Service then notices impacted members on behalf of all Health Networks.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Customer Service	Customer Service	**Monthly: 10th of every month**	2_CSRPT_HNRPT_**HN**_PreclusionList_**YYYYMM**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	hn_reporting	Excel	x	x	x	x	x	x		x
Directed Payments File	Health Networks shall submit monthly Directed Payment adjustment report for qualifying services.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/HNR	HNR	**Monthly: 10th of every month**	1_HNRPT_DirectedPayment_**HN_YYYYMM**.csv	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD = 2 digit day	hn_reporting	Excel	x			x	x			x
Kaiser WCM Rx Detail	Kaiser shall submit monthly report of WCM Rx payment information.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Pharmacy Management	Pharmacy	**Monthly: 15th of every month**	WCM04RXCCYYMMDD	MM = 2 digit month YYYY = 4 digit year	incoming	Excel	x				x			x
FDR Compliance Attestation	The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation.	https://www.caloptima.org/~/media/Files/CalOptimaOrg/508/Vendors/ComplianceFDRs/2020-08_CalOptimaFDRProgramAttestation_508.ashx	Office of Compliance	**Initial upon contracting; Annually thereafter**	FDR Compliance Attestation	N/A	email to compliance@caloptima.org	PDF	x	x	x	x	x	x	x	
Claims Timeliness Report	Health Networks shall submit a monthly claims payment performance (timeliness) report.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Claims/Claims Timeliness Report	Claims	**Monthly 15th of every month** **Quarterly January 30, April 30, July 30, October 30**	1_CLMRPT_**HN_MMYYYY**_MTR_**LOB** (Monthly) 1_CLMRPT_**HN_QTYYYY**_MTR_**LOB** (Quarterly)	HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year LOB=MC, OC, DB	hn_reporting	Excel	x	x	x	x	x	x	x	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Annual Audit	Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for CalOptima's Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements. The deliverables may include road mapped audit tools for the areas reviewed, supporting policies, and procedures, evidence of staff training, committee minutes, attestations, desktop procedures, and other documentation identified throughout the course of the audit for the following areas, as applicable: • Access & Availability • Care Delivery Model • Claims • Compliance • Credentialing • Cultural & Linguistics • Customer Service • Encounters • Information Systems • Mailroom Process • Marketing • Medi-Cal Addendum • Member Grievances & Appeals • Network Management • Provider Network Contracting • Provider Relations • Quality Improvement • Sub-Contractual • Translation Services • Utilization Management • Whole Child Model	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 6, Provision 13 Medicare Managed Care Manual, Chapter 11, Section 110.2 APL 17-004: Sub-Contractual Relationships and Delegation	Annually: per process	X	X	X	X	X	X
Claims XML Universe	Health Networks shall submit a complete Claims XML universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. The report includes the following: • Claim version (the version number of the xml specification), as of date (the date the xml specification was released), entry ID (incremental numeric count used as a unique identifier in CalOptima's file loading process) • CalOptima Line of Business (LOB) • Claim number, form type, bill type in UB04, admission code, place of service name and code • Authorization number • Was claim adjusted and clean • Whole Child Model (WCM) principal procedure code, principal procedure code date, other procedure code dates, type of services, patient discharge status, condition codes, diagnostic related grouping (DRG) – (UB04 forms), Division of Financial Responsibility (DOFR), expense type	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy HH.2015: Health Network Claims Processing Cal MediConnect 3-Way Contract, Sections: 2.2.4 5.1.9 5.1.9.2 5.1.10	Monthly: 2nd of every month	X	X	X	X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Beneficiary name, Client Identification Number (CIN), threshold language • Requestor type, receipt date and time • Date and time of additional information requested (AIR) • Billing provider name, provider national provider identification (NPI), Tax ID, specialty, contracted status • Rendering provider name, NPI, Tax ID, specialty, contracted status • Medical necessity denials • Date and time claim received, loaded in system, decision made, claim redirected • Payment information method, number, print date and time, transfer date and time • Mail date and time of written notification to member and provider • Decision maker name, title and credentials • International Classification of Diseases (ICD) entry type, code, description, primary entry for Whole Child Model (WCM) present on admission and admitting • Date of service • Billed revenue code, description, Current Procedural Terminology (CPT), Healthcare Common Procedure Code (HCPC) descriptions, modifier and modifier description, units and amount • Paid revenue code, description, and CPT/HCPC • Paid CPT/HCPC description, modifier, modifier description, units, amount, withhold amount, interest amount, adjustment code, adjustment code description • Paid reason for CPT/HCPC change • Decision type and decision denial reason	DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4 Medicare Managed Care Manual Chapter 11, Section 110.2 Title 42, Code of Federal Regulations (CFR), Sections: 422.520 (a) 447.45 (d)							

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Claims Universe Case Files	Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: <u>Paid Claims:</u> • Copy of claim and receipt date (if electronic claim, a print screen showing date of receipt), and date claim is entered in health network system (acknowledgement date) • Authorization, if applicable • Remittance advice (RA) or explanation of payment/explanation of benefit (EOB) with interest if applicable • Proof of check clearing (bank statements or copy of cancelled check) <u>Denied/Contested Claims:</u> • Copy of claim and received date (if electronic claim, a print screen showing received date), and date claim is entered in health network system (acknowledgement date) • Eligibility print screen if contested/denied for eligibility • System notes pertaining to claim • If applicable, denial letters for member liability denials and any supporting documents used to determine the denial • RA/EOB with interest, if applicable <u>Adjustments:</u> • Copy of original claim and receipt date (if electronic claim, a print screen showing date of receipt) • Original RA/EOB showing payment or denial • Date of discovery that adjustment occurred (customer service call, internal audit, project, refund check, etc.) • Reason for adjustment (system notes, eligibility or retrospective eligibility screen, etc.) • All information/documentation for claim development (i.e., emergency room report, medical records) including applicable dates of request and receipt, and reason for claims development • RA/EOB with applicable interest • Proof of check clearing (bank statements or copy of cancelled check) for adjusted claim	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy HH.2015: Health Network Claims Processing Cal MediConnect 3-Way Contract, Sections: 2.2.4 5.1.9 5.1.9.2 5.1.10 DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.520 (a) 447.45 (d)	Monthly: 10th of every month	X	X	X	X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Credentialing Monthly Universe	Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. The report includes the following: • Health Network name, reporting month and year • Whether there are initially credentialed (IC), recredentialed (RC), or terminated (TM) practitioners on the report • Data ID (IC/RC/TM) • CalOptima program (Medi-Cal, OneCare, OneCare Connect) • Individual practitioner name, license number and type • Contract type and primary contracted specialty • Current and previous credentialing decision dates • Whether board certified, board certified specialty, initial board certification issue date, and board certification expiration date • Current facility site review date • Current, signed attestation date • Termination date and reasons for termination • Date Change Termination (CT) form was submitted	NCQA Standards, Credentialing/Recredentialing: CR3 CR4 APL 17-004: Sub-Contractual Relationships and Delegation APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.10.5 2.16.3.3 DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions: 6 12 Medicare Managed Care Manual: Chapter 6, Section 60.3 Chapter 11, Section 110.2	<u>Health Networks and Kaiser</u> Monthly: 2nd of every month <u>VSP</u> Quarterly: January 10, April 10, July 10, October 10	X	X	X	X	X	X
Credentialing Universe Monthly Case Files	Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: <u>Initial Credentialing</u> • Initial credentialing approval form (signed by Medical Director/Authorized Representative) or credentialing approval letter • File checklist • Application with all pertinent information for the review (including, at a minimum, attestation and data release authorization) • License verification • Copy of DEA certificate or verification of DEA registration • Work history, and education and training verification • Board certification verification, as applicable	NCQA Standards, Credentialing/Recredentialing: CR3 CR4 APL 17-004: Sub-Contractual Relationships and Delegation APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities	Monthly: 10th of every month	X	X	X	X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage • Copy of current malpractice/professional liability policy • National Practitioner Data Bank query • State sanctions or restriction on licensure verification • Medicare/Medicaid sanction verification • Office of Inspector General (OIG) review • System for Award Management (SAM) review • Medi-Cal Suspended and Ineligible review • Medicare opt-out review • CMS Preclusion List review • Current Facility Site Review, if applicable • Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners) • Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners <u>Recredentialing</u> • Recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter • Previous recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter • File checklist • Performance monitoring documentation • Application with all pertinent information for the audit (including, at a minimum, attestation and data release authorization) • License verification • Copy of DEA certificate or verification of DEA registration • Board certification verification, as applicable • Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage • Copy of current malpractice/professional liability policy • National Practitioner Data Bank query • State sanctions or restriction on licensure verification • Medicare/Medicaid sanction verification • Office of Inspector General (OIG) review • System for Award Management (SAM) review • Medi-Cal Suspended and Ineligible review • Medicare opt-out review • CMS Preclusion List review • Current Facility Site Review, if applicable • Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners) • Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners	CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.10.5 2.16.3.3 DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions: 6 12 Medicare Managed Care Manual: Chapter 6, Section 60.3 Chapter 11, Section 110.2							
Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required. The report includes the following: • Member identifier, medical record number, and facility service type • Date of termination request/notice and date of actual termination	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.9 Medicare Managed Care Manual, Chapter 11, Section 110.2	Monthly: 2nd of every month		**X**	**X**	**X**		

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Date the termination request/notice was given to member/member's representative, and date member/member's representative signed for receipt • Date of discharge	Title 42, CFR, Sections: 405.1200 (b)(1) & (2) 422.624 (b)(1) and (2)							
NOMNC Files (OneCare & OneCare Connect)	Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results. NOMNC files include the following: • Service Type: Skilled Nursing Facility (SNF), home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services • Date of termination request • Date of actual termination (including date, time and name of provider making the request) • Date of termination request/notification to the member/member's representative (must be made no later than two (2) days before the termination of services) • Member/member's representative notified of appeal rights • Date of termination request/notification signed by the member/member's representative • Copy of signed NONMC letter • Date of discharge If member is incapable of providing a signature and member's representative is not present at the time of the termination request, the following is required: • Documentation indicating the date the provider spoke with the member's representative (date of the conversation is the date of receipt of the notice) • Proof of letter mailed on same date of call made to member's representative • If provider is unable to reach member's representative by phone, provide proof of the following: o Certified mail receipt with return receipt request o Date someone at the representative's address signs or refuses to sign the letter o Ensure facility compliance of placing dated copy of the certified mail receipt in the Member's medical file	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.9 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 405.1200 (b)(1) & (2) 422.624 (b)(1) and (2)	Monthly: 10th of every month		X	X	X		
Provider Dispute Resolution (PDR) XML Universe	Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. The report includes the following: • Entry ID and line of business (Medi-Cal, OneCare, OneCare Connect) • Unique ID number used to track authorization request • Date and time for the following: the PDR request was received, the PDR acknowledgement letter was sent to the provider, and the final decision was made on the PDR • Check number used to pay overturned PDR request, and date and time check was mailed • Date and time the written notification was provided to the provider • Name and title of the decision maker of the PDR request	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2	Monthly: 2nd of every month	X	X	X	X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Whether additional information was requested to process PDR, date additional information was requested, and date additional information was received • Billing provider's name, NPI number, tax ID number, specialty, and whether contracted • Claim number of the original claim being appealed, and decision date and time of the original claim being appealed • Member's name, CIN, and preferred language • ICD type and diagnosis code • Start date and end date of services rendered • Billed revenue code, CPT/HCPC code, and modifier • Billed units and billed amount • Paid amount (excluding interest), withhold amount, and paid interest amount • Decision type (upheld means denial of payment and overturned means original decision overturned for payment), and upheld/overturned reason • Adjustment code and description	Health and Safety Code (HSC), Section 1367: (h)(1) (2) Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 28, California Code of Regulations (CCR), Section 1300.71.38: (b) (c) (d)							
PDR Universe Case Files	Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: • Copy of original claim, and received date (if electronic claim, a print screen showing received date) • Original RA/EOB showing payment or denial • Provider dispute request along with pertinent documents submitted, and date received • All information/documentation for PDR development (i.e., emergency room report, medical records), including applicable dates of request and receipt, and reason for PDR development • Acknowledgement letter, and resolution letter sent to provider • EOB showing payment with applicable interest, if original decision of payment denial is overturned • Proof of check clearing (bank statements or copy of cancelled check) if payment is issued	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2 HSC, Section 1367: (h)(1) (2) Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 28, CCR, Section 1300.71.38: (b) (c) (d)	Monthly: 10th of every month	X	X	X	X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Provider Directory Universe Case Files	Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results. The Provider Directory file review is based on a signed and dated provider attestation that includes the following: • Provider name, California license number, and gender • Address (office locations), office days and hours, day phone number, and after-hours phone number • Administrative email address, or office fax number (if no administrative email available) • Languages spoken by provider and staff • Primary specialty (i.e. dermatology, internal medicate, etc.) • Accepting new patients (i.e., open or closed panel), and age restrictions • Medical group affiliations, health network affiliations, and facility affiliation (i.e., hospital) • Special services (i.e. California Children's Services and/or Child Health and Disability Prevention (CHDP) • Programs (i.e. Medi-Cal, OneCare, OneCare Connect) • Provider type in this network (i.e. Primary Care Provider, Specialist) • Provider Type 1 NPI (if applicable), Type 2 NPI (if applicable), taxonomy, and Tax ID number • Validation statement: "A provider's failure to validate and attest to the accuracy of their Provider directory data may result in panel closure, suppression from the provider directory, and/or delay of payment." • Designated space for printed name, signature and date for the provider office manager or equivalent staff	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Health Network Contract, Section 7.10 CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.17.5.11 DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 4.D.4 HSC, Section 1367.27 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Section 438.10 (h)	Annually, per request	X	X	X	X		

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Utilization Management (UM) XML Universe	Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. The report includes the following: • Version, as of date, entry identification (ID), and line of business (LOB) for this authorization • ID number used to track the authorization request (AR), and type of AR • Whether authorization is for Part B or physician administered drugs and/or administration • Whether authorization is for visits/services which require a care plan in coordination with PCP, and continued care from a specialist • Method AR was received, and authorization number related to AR • CMS place of service code and name • Type of services: behavioral health services, long term services and supports, substance use services, or other types of services (specified by Health Network) • Member name, CIN, and preferred language • AR requestor (member/ member's representative, contracted/non-contracted provider, service/care coordinator) • Date and time the Appointment of Representative (AOR) was received by delegate (unless no AOR form submitted or Medi-Cal LOB) • Whether additional information was requested to process authorization, and if so, date the request was sent and date information was received • Requesting provider/group/facility name, NPI, tax ID number, and whether contracted • Requested provider/group/facility name, NPI, tax ID number, specialty, and whether contracted • Approved provider/group/facility name, NPI, tax ID number, specialty, and whether contracted • Date and time of decision, and whether decision was processed as "Medical Necessity" or otherwise (Covered Benefit) • Date and time service authorization/approval was entered in Health Network's system (date and time authorization was effective), and authorization expiration date • Date and time AR was received, whether AR was requested as expedited, and whether AR was processed under the expedited timeframe • If AR was requested under expedited timeframe, whether Health Network determined the request did not meet expedited criteria and instead process the AR under the standard timeframe • If a request to expedite was made after the original request, identify requestor of subsequent request to expedite • Whether a timeframe extension was taken • Date and time for the following: the member was notified of extension, the provider was notified of extension, the written notification to the member was printed, the written notification to the member entered the mail stream, the attempted oral notification(s) to the member, and the oral notification was provided to the member • The method used to initially notify the requesting provider of the decision of authorization request • Date and time for the following: the initial notification was provided to the requesting provider, the written notification to the provider was printed, and the written notification to the provider entered the mail stream • Whether the review was completed by a physician or other appropriate health care professional • Name, job title, and credentials of the decision maker of the AR • Whether the primary ICD code was related to the AR, and ICD diagnosis code and short description • Code type (revenue or CPT or HCPC or CDT) and code of the requested service, description of the CPT/HCPC/CDT code, and number of requested units • Code type (revenue or CPT or HCPC or CDT) and code of the approved service, description of the CPT/HCPC/CDT code, and number of approved units • Determination of the requested service • Reason for the denial or modification of the requested service	NCQA Standards, Utilization Management, UM5 APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1541: Utilization Management Delegation CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.6.3 2.11.7 2.11.9 DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions: 2 3 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.572(a) & (b) 422.568 (b)(1) Medicare Part C Reporting Requirements, Section VI	Monthly: 2nd of every month	X	X	X	X	X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
UM Universe Case Files	Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. UM case files include the following documentation: <u>Medi-Cal</u> • Approval file checklist includes all medical records attached to file and transaction log • Denial file checklist includes denial letter with attached language assistance program (LAP), all medical records attached to the file and transaction log • Modification file checklist includes modification letter with attached LAP, all medical records attached to the file and transaction log <u>OneCare</u> • Approval file checklist includes approval letter with attached LAP, all medical records attached to the file, transaction log, and provider notification fax, if available • Denial file checklist includes denial letter, all medical records attached to the file and transaction log <u>OneCare Connect</u> • Approval field checklist includes approval letter with attached LAP, all medical records attached to file, transaction log, and provider notification fax, if available • Denial file checklist includes denial letter, all medical records attached to the file, transaction log, and provider notification fax, if available	NCQA Standards, Utilization Management, UM5 APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1541: Utilization Management Delegation CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.6.3 2.11.7 2.11.9 DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions: 2 3 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.572(a) & (b) 422.568 (b)(1)	Monthly: 10th of every month	X	X	X	X	X	
Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser	Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data. The report includes the following: • Plan code, name, county and reporting period • Number of CDE referrals • Number of referrals determined appropriate for CDE • Number of CDE completed • Number of CDE appointments scheduled within and outside timely access • Number of CDE not scheduled but offered appointment • Number of CDE with appointment not yet scheduled • Comments	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6	Monthly: 15th of each month	X				X	
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	Kaiser shall submit the Mental Health Report, containing mental health grievances and appeals data. The report includes the following:	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6	Quarterly: January 20, April 20, July 20, October 20	X				X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Plan code, name, county, reporting quarter and total number of members • Number of referrals: by Specialty Mental Health Plan (SMHP) to Managed Care Plan (MCP), by MCP to SMHP within the county, to MCP mental health provider, by MCP to SMHP outside the county including outside county code • Number of grievances received for the following: psychotherapy (evaluation and treatment), outpatient services, laboratory/supplies, access to SMHP, authorization/referral to SMHP, medication/pharmacy, and all others including a description • Number of grievances: resolved within thirty days, pending less than 30 days, pending more than 30 days and resolved from a previous reporting period • Number of mental health continuity of care (COC) approvals, average number of days taken to approve requests and the average number of sessions COC requests were approved for • Average number of days taken to deny requests • Number of denials for care relationship not established, quality of care, rate disagreement, provider refusal to work with plan and all others including a description • Number of COC requests in process and comments								
Case Management Log	Health Networks shall submit monthly Case management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services. The report includes the following: • Member name, CIN, date of birth, and program • Diagnosis and ICD-10 code (qualifying member for case management) • Referral/data source to case management, date opened, and date closed • Case management level, status change reason, and complex case trigger • Additional programs to which member has been referred • Special program to which member is enrolled, or any special needs of member	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 1 Attachment 11, Provision 2 APL 17-004: Subcontractual Relationships and Delegation NCQA Standards, Population Health Management: PHM5 PHM7	Monthly: 15th of every month	X		X	X	X	
Continuity of Care (Whole-Child Model)	Health Networks shall submit weekly report of COC for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month. The report includes the following: • Requestor type, date of request, and request type • Member name and CIN • COC begin processing date and date of decision • COC completion date (including member notification) and COC expiration date • Requested provider NPI and provider type • Decision outcome, denial reason, and explanation of other reasons • Next steps taken for incomplete requests	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 10	Weekly: Every Tuesday by 10 am for the prior week's activity	X			X	X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Enhanced Monitoring Report (WCM)	Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members. The report includes the following: Health Networks (including Kaiser): • Describe any challenges with care coordination and Health Network's role in overcoming barriers • Describe any disruption with pharmacy needs, the steps, and the timeline Health Network is taking to ensure COC with prescriptions • For each of the four (4) rare subspecialists (pediatric dermatology, pediatric developmental and behavioral medicine, oral and maxillofacial surgery, and transplant hepatology), describe the number of out-of-network requests that have occurred during the reporting period and outcomes Kaiser Only: • Describe any challenges with completing assessments, specifically with high risk members, and the impact on the development of the ICP • Identify any barriers to conducting pediatric health risk assessments and actions the Health Network is taking to improve completion	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 10	Quarterly: 5th day after the end of the quarter	X			X	X	
Health Homes Program (HHP) Enrollment and Disenrollment Report	Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month. The report includes the following: • Member name, CIN, and date of birth • Whether HHP enrolled member was externally referred • HHP disenrollment date and reason • Whether member is homeless/at risk for homelessness, or received housing services during reporting period • Whether member was homeless at any point during enrollment in HHP • Whether member is no longer homeless as of the last day of reporting period • File create date	DHCS HHP Program Guide CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	
HHP Finalized Engagement List (FEL) Return File	Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes. The Health Network response file includes the following: • Excluded because not eligible-well managed: Y/N • Excluded because declined to participate: Y/N • Excluded because of unsuccessful engagement: Y/N • Excluded because of duplicative program: Y/N • Excluded because of unsafe behavior or environment: Y/N • Excluded because not enrolled in Medi-Cal at MCP: Y/N • Enrollment date (if applicable)	DHCS HHP Program Guide CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
HHP Services	Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities. The report includes the following: • Claim line ID • Health Network ID, claim number, claim line number • Member name and CIN • Date of service and service provided • Claim or encounter received date • Whether an adjustment, and previous claim number • Rendering provider name and NPI • Billing provider name, NPI, and Tax ID • Billed CPT code and modifier, and primary diagnosis • Units billed and provider billed amount • Paid amount, and adjustment code • Fee-for-service or capitated claim • Check or EFT transaction number • Optional user defined fields	DHCS HHP Program Guide CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	
Implementation Audit (OneCare Connect)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 DPL 15-001: ICP and ICT Requirements, Section A. Care Plans Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA1.5 CA1.6 CY2020 Medicare-Medicaid Plans (MMP) Core Reporting Requirements	Ongoing, per process			X	X		
Implementation Audit (OneCare)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Medicare Managed Care Manual, Chapter 5	Ongoing, per process		X		X		

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Implementation Audit (Seniors and Persons with Disabilities or SPD)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X		
Organ Transplant – Kaiser	Kaiser shall submit monthly report of members engaged in the organ transplant process. The report includes the following: • Member name, CIN, and date of birth • Transplant related diagnosis and transplant type • DHCS-approved transplant center where member will be transplanted • Date the Health Network notified CalOptima of member's potential transplant status • Current transplant phase and the date the phase began • Date member is listed for transplant at DHCS-approved transplant center • Date member was last contacted regarding case management/coordination care issues • Date the transplant case is closed and reason for case closure • Case manager name • Additional comments to clarify report	APL 17-004 Subcontractual Relationship and Delegation: Monitoring Subcontracted and Delegated Functions Cal MediConnect 3-Way Contract, Section 2.2.4	Monthly: 15th of every month	X				X	
Annual Redetermination Files	Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination. The report includes the following: • Report(s) from specialists/subspecialists substantiating the member's continued/ongoing treatment for their identified CCS condition(s) to support CCS annual redetermination. • WCM face sheet that includes the member's name, Health Network, CIN, age, date of birth, CCS condition, and redetermination date.	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Section 6 Attachment 11, Section 10	Ongoing, per process	X			X	X	
Individual Care Plan/Health Action Plan (ICP/HAP) bundle	Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date. The report includes the following: • Final signed HAP/ICP that include documentation of an initial CML and any changes in CML since the member's enrollment, and address the member's identified needs and barriers to accessing care, community-based support referrals, transitional care if the member was hospitalized or required outpatient treatment, health promotion referrals as appropriate, and self-management skills. • Completed HNA that identifies members experiencing homelessness and any referrals to housing services, and member's voice in planning and decision making including their stated goals.	Medi-Cal Health Homes Program Guide APL 18-012: Health Homes Program Requirements	Ongoing, per process	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Clinical assessments/case management notes								
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA 1.1 - CA 1.5 OneCare Connect 2018 Model of Care, MOC 2, Element C, Section 4 Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 Medicare Managed Care Manual, Chapter 5, Sections: 20.2.1 2.C and D DPL 15-001: ICP and ICT Requirements	Ongoing, per process			X	X		
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X		
ICT Bundle (OneCare)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Medicare Managed Care Manual, Chapter 5	Ongoing, per process		X		X		

Timely and Appropriate Submission Grid – Supplemental Attachment

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				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Long Term Care (LTC) ICP Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Final ICP that includes assessments, interventions, and goals set by the facility • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	OneCare Connect 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 DPL 15-001: ICP and ICT Requirements CY 2020 Medicare-Medicaid Plan (MMP) Core Reporting Requirements, Section 3.2	Ongoing, per process			X	X		
Pediatric ICT Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels. The report includes the following: • ICT notes/minutes, participants invited according to member's needs, and ICT attendees • Clinical Assessments/Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Copy of Care Planning Letter sent to Member with date mailed and preferred language and format • Copy of the final ICP signed by the PCP	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X		
Model of Care (MOC) SPD Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed) Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM.	DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2	Monthly: 6th of every month	X			X	X	
MOC Tracking Log (OneCare Connect)	Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number	Cal MediConnect 3-Way Contract, Sections: 2.5.2.7 2.5.2.7.1	Monthly: 6th of every month			X	X		

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Care Management Level (CML) • Reason for change in CML (if changed)								
MOC Tracking Log (OneCare)	Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed)	Title 42, CFR, Section 422.101(f)	Monthly: 6th of every month		X		X		
MOC WCM Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed) Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM.	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)	Monthly: 6th of every month	X			X		
Network Staff Legend File	Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OneCare Connect only). This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Staff name, number (unique for each individual PCC or CC, phone number, and email • For OneCare Connect only, CC hire date and termination date, and whether CC performed assessments • Model of Care (MOC) training received • PCC training received and PCC staffing ratio met • Percentage of time staff person spent performing work on each program (OneCare Connect, OneCare, SPD, and WCM), and on behalf of other health plans • Type of licensed staff or non-licensed CC staff • Attestation from Manager/Director (name and title) to report information	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) Cal MediConnect 3-Way Contract, Sections: 2.5.2.7 2.5.2.7.1 DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2 Title 42, CFR, Section 422.101(f)	Monthly: 6th of every month	X	X	X	X		

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
WCM ICP Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 calendar days of HRA completion. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)	Ongoing, per process	X			X	X	
DHCS WCM Report - Kaiser	Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, and reporting period • Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME • Number of members identified as high risk and as low risk • Number of WCM assessments completed to date for high risk members and for low risk members • Number of WCM ICP completed to date for high risk members • Number of WCM eligible members with diagnosis requiring a referral to SCC to date • Number of WCM eligible members who have been seen by SCC to date • Number of WCM member discharged from hospital to date • Number of WCM members discharged from hospital with at least one follow-up visit within 28 days after discharge date • Number of grievances received regarding the following: timely access, transportation, DME, and WCM provider • Number of other WCM grievances and summary of such grievances • Number of WCM appeals and summary of appeals	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4 Attachment 11, Provision 10	Monthly: 15th of every month	X				X	
Population Health Management (PHM) Program Description - Kaiser	Kaiser shall develop a PHM program description and submit to CalOptima for review. The report includes the following: • Quantitative results for relevant clinical, cost/utilization and experience measures • Comparison of results with a benchmark	NCQA Standards, Population Health Management, PHM7	Annually: February 15th	X				X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS WCM Report	Health Networks shall submit monthly report of WCM authorizations and care coordination. The report includes the following: • Plan code, plan name, county, and reporting period • Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME • Number of members identified as high risk and as low risk • Number of WCM assessments completed to date for high risk members and for low risk members • Number of WCM ICP completed to date for high risk members • Number of WCM eligible members with diagnosis requiring a referral to SCC to date • Number of WCM eligible members who have been seen by SCC to date • Number of WCM member discharged from hospital to date • Number of WCM members discharged from hospital with at least one follow up visit within 28 days after discharge date	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11 Provision 10	Monthly: 15th of every month	X			X		
Claims Third Party Liability (TPL) (Medi-Cal)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. The report includes the following: • Member name, ID number, date of birth, and date of death (if applicable) • Contractor's name (CalOptima) • Provider name(s), and date of service • Diagnosis code(s) and description of illness or injury • Procedure codes(s) and description of services rendered • Amount subcontractor or out-of-plan Provider billed, if applicable • Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable • Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable	CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability (TPL) APL 17-021: Workers' Compensation – Notice of Change to Workers' Compensation Recovery Program, Reporting and Other Requirements Cal MediConnect 3-Way Contract, Section 5.1.13.1 DHCS Medi-Cal Contract, Exhibit E, Attachment 2	Monthly: 30th of every month	X			X	X	
Claims TPL (OneCare Connect)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. The report includes the following: • Member name, ID number, date of birth, and date of death (if applicable) • Contractor's name (CalOptima) • Provider name(s), and date of service • Diagnosis code(s) and description of illness or injury • Procedure code(s) and description of services rendered • Amount subcontractor or out-of-plan provider billed, if applicable • Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable • Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable	CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability Title 42, CFR, Sections: 405.378 411.24 422.108 423.462 CMS Memorandum to MAOs and PDPs (12/5/11), "Medicare Secondary Payment Subrogation Rights" Cal MediConnect 3-Way Contract, Section 5.1.13	Monthly: 30th of every month			X	X		

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS Post-Payment Recovery Report (Medi-Cal Only)	Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima. The report includes the following: • Project type (Third Part Liability "TPL") • Name of Provider billing the claim, and provider tax ID number • Claim type (What kind of claim was submitted, Facility, Professional, etc.) • Member name, date of birth, ID number, and social security number • Transaction control number (claim number) • Begin date and end date of service • Coordinated care organization bill amount (amount billed to TPL/Provider) • Coordinated care organization paid amount (amount paid to the Provider) • Bill date (date the claim was billed to the TPL) • Remit amount (amount recovered from the TPL) • Claim date of remit (date the claim was paid or denied by TPL) • Check number related to remit amount • Other insurance carrier name (name of the TPL that was billed) • Claim status (disposition of the claim, paid, denied, open, etc.) • Denial reason (the reason the claim was denied by the TPL)	APL 20-010: Cost Avoidance and Post-Payment Recovery for Other Heath Coverage	Monthly: 3rd business day of every month	X			X	X	
Customer Service Call Log Universe	Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring. The report includes the following: • File ID number, and line of business • Member name and cardholder ID (assigned by HN to identify member) • Date and time the call was received • Category of the call and detailed description of the call • Detailed description of the outcome/resolution of the call • Date and time the call was resolved • Customer Service Representative name who handled the call • Member's language	DHCS Medi-Cal Contract, Exhibit A: Attachment 13, Provision 2 Attachment 14, Provision 1 Attachment 14, Provision 2 Health and Safety Code (HSC), Section 1368(a)(1) Title 28, CCR, Section 1300.68(a) Cal MediConnect 3-Way Contract, Section 2.14 Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance	Quarterly: January 7, April 7, July 7, October 7	X	X	X	X		

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Health Network Dashboard	Health Networks shall submit report of call center statistics for monthly review. The report includes the following: • Total number of calls, average speed of answer, and average length of call in seconds • Service levels (percentage of incoming calls answered within 30 seconds) • Average speed to answer member services telephone calls with a live voice • Abandonment rate (percentage of incoming calls disconnected) • Number of calls received by call type (questions, grievance and appeals, health education requests, transportation, authorization/referral, member claims, access to services) • Number of calls by language	CalOptima Health Network Contract, Sections: 3.5 7.1 DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 3	Monthly; 15th of every month	X	X	X	X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Interpreter Services Utilization Report	Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks. The report includes the following: • Requests for interpreter services by language (number of requests received, and number of requests fulfilled) • Number and percentage of telephonic interpreter services provided by the following: Contracted vendor, community-based organization (CBO), HN staff, and provider/provider staff • Number and percentage of face-to-face interpreter services provided by the following: Contracted vendor, CBO, Health Network staff, and provider/provider staff • Total cost for interpretation and/or translation services with an outside vendor or CBO (if services subcontracted)	DHCS Medi-Cal Contract, Exhibit A, Attachment 6 Cal MediConnect 3-Way Contract, Section 2.11.1.2.2	Quarterly: January 30, April 30, July 30, October 30	X	X	X	X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS NMT/NEMT Report – Kaiser	Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, and reporting period • Number of NMT trips by private transportation to covered services for age 20 and under, and for age 21 and above • Number of NMT trips by private transportation to non-covered services for age 20 and under, and for age 21 and above • Number of NMT trips by public transportation to covered services for age 20 and under, and for age 21 and above • Number of NMT trips by public transportation to non-covered services for age 20 and under, and for age 21 and above • Number of NMT denials • Number of NMT and NEMT calls • Number of NMT and NEMT grievances, and grievance reasons • NMT/NEMT reporting comments	APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services DHCS Medi-Cal Contract, Exhibit A, Attachment 10 Welfare and Institutions Code, Section 14132	Monthly: 27th of every month	X				X	
Annual Audited Financial Statements	Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only). Audited financial statements include the following: • Letters to management, and incurred but not reported (IBNR) documentation • Consolidated corporate audited financial statements (if Health Network is part of a larger entity)	CalOptima Policy FF.3001: Financial Reporting	Annual submission due 120 days after organization's fiscal year ends	X	X	X	X		

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Balance sheet, statement of revenue and expenses, statement of cash flows, audit opinion, and related notes and disclosures								
Incurred But Not Reported (IBNR) Documentation	Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report. The IBNR documentation includes the following: • Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims • Supporting documentation for the IBNR calculation	CalOptima Policy FF.3001 Financial Reporting	Annual submission due 120 days after organization's fiscal year ends	X	X	X	X		
Medical Loss Ratio (MLR)	Health Networks shall submit interim and final reports of the Health Network MLR. MLR submission shall utilize the most current Annual Financial Reporting Form (AFRF) provided by CalOptima. Medi-Cal Expansion and Whole Child Model reported separately from Medi-Cal (classic). SRG completes only the "P" tabs. PHC completes the "P" and "H" tabs. HMO (except Kaiser) completes the HMO template.	CalOptima Policy FF.3001: Financial Reporting	Interim: January - June due August 15 Interim: January - December due February 15 Final: Annual submission of all 12 months due June 30	X		X	X		
Risk Bearing Organization (RBO) Report	Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only). RBO submissions includes a copy of the DMHC RBO Quarterly and Annual Financial Survey Report, pursuant to 28 CCR Section 1300.75.4.3.	CalOptima Policy FF.3001: Financial Reporting	Annual submission due 150 days after the fiscal year ends Quarterly: February 15, May 15, August 15, November 15	X	X	X	X		
Total Business Reports	Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization.- Quarterly unaudited statements include balance sheet, income statement, statement of cash flows, and related disclosures.	CalOptima Policy FF.3001: Financial Reporting	Quarterly: February 15, May 15, August 15, November 15	X	X	X	X		
DHCS Quarterly Report - Kaiser	Kaiser shall submit quarterly report of grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Year, quarter, plan code, member CIN • Grievances by categories: Accessibility, benefits/coverage, referral, quality of care/services, and other • For the other category, grievance type(s) must be defined by HN • Whether grievance was resolved (in favor of member or HN) or unresolved	CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process DHCS Medi-Cal Contract, Exhibit A, Attachment 14, Provision 3 APL 14-013: Grievance Report Template	Quarterly: January 23, April 23, July 23, October 23	X				X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
		APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments							
Grievances Volume Report - Kaiser	Kaiser shall submit quarterly report of grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Number of the following grievance types: Coverage disputes, disputes involving medical necessity, quality of care, access to care (including appointments), quality of service, and other • Total of all grievance types	CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process DHCS Medi-Cal Contract: Exhibit A, Attachment 14, Provision 3	Quarterly: January 23, April 23, July 23, October 23	X				X	
Community-Based Adult Services (CBAS) Report - Kaiser	Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, reporting quarter • Number of requests for CBAS, and number of CBAS Providers • Number of members by the following categories: received initial CBAS assessment, ineligible to receive CBAS, received enhancement case management (ECM) services, provided with CBAS, and provided with unbundled services • Average number of days between CBAS request and notice of eligibility • Number of members discharged due to: death, long term nursing facility placement, other services, moving out of the plan, choosing to leave CBAS, and transfer to a different CBAS center • Number of grievances regarding: CBAS Providers, contractor assessment/reassessment, excessive travel times to access CBAS, and other CBAS grievances • Number of CBAS appeals approved, denied, and withdrawn • Number of CBAS appeals related to: denials/limited services, denied access to requested CBAS provider, and excessive travel times to access CBAS • Number of CBAS complaint calls from member and from provider • Explanations and summary of CBAS complaints • CBAS reporting comments	CalOptima Health Network Contract, Exhibit A, Attachment 19, Provision 6	Quarterly: January 23, April 23, July 23, October 23	X				X	
DHCS Data Certification Statement	Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful. The most current template Data Certification Statement in the Report Binder shall be utilized and include the following: • Health Network name, certification month and year • Signature of Health Network CEO or CFO (or an individual who reports directly to and has delegated authority to sign for such Officer) • Signature date, job title, and Health Network department.	APL 17-005: Certification of Document and Data Submissions DHCS Medi-Cal Contract, Exhibit E, Attachment 2 CalOptima Health Network Contract, Section 7.12	Monthly: 25th of each month	X			X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Health Network Newly Contracted Provider Training Report	Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training. The report includes the following: • Program (Medi-Cal, OneCare, OneCare Connect) • Provider name, NPI, and active status date • Date the training started and date the training was completed • Whether signed acknowledgment was received from provider • Comments/explanation of missed deadline(s)	CalOptima Policy EE.1103: Provider Education and Training DHCS Medi-Cal Contract, Exhibit A: Attachment 7, Provisions 5 Attachment 9, Provision 12 APL 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities Cal MediConnect 3-Way Contract, Section 2.9.11	Quarterly: January 25, April 25, July 25, October 25	X	X	X	X	X	X
Primary Care Provider (PCP) Upload File	Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes. The report includes the following: • Member site, ID, and suffix • PCP effective date, ID, and suffix • Health Network ID and suffix • Medical center ID and suffix • Staff Vs center indicator • Pay to Tax ID number (Health Network Tax ID) • Pay to Tax ID suffix • PCP reason code • Name of individual provider, group, or clinic	CalOptima Health Network Contract, Sections: 3.12 7.1 7.11 CalOptima Health Network Contract (PHC and SRG), Section 3.10.5.4 CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider (PCP)	Bi-monthly: 10th and 25th of every month	X			X		
DHCS Supplemental Data – Kaiser	Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS. The report includes the following: • Supplement type: AIDS, maternity, Hep-C, behavioral health treatment (BHT), Health Homes Program Physical Conditions and Substance Use Disorder (HHP-PHYS-SUD)/HHP Serious Mental Illness (HHP SMI). • Member name and CIN • Health Care Plan (HCP) code • Month of service • Member enrollment status indicator • Services rendered • Diagnosis date • Delivery date • Number of weeks for Hep-C multiplier • Indicator for correction record • Indicator for Hep-C medications: Sovaldi, Olysio, Incivek, Victrelis, Harvoni, Viekira Pak, Technivie, Zepatier, Epclusa, Viekira XR, Vosevi, Mavyret	DHCS Medi-Cal Contract, Exhibit B, Budget Detail and Payment Provisions, Provision 16 Technical Guidance: Consolidated Supplemental Upload Process	Monthly: 15th of every month	X				X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Number of encounters								
Vision Service Plan (VSP) Provider Roster	VSP shall submit monthly report of VSP providers for the print and online provider directories. The report includes the following: • Practice name, doctor name, and provider specialty • Provider address, phone number, and county name • Non-English languages spoken by provider and/or clinical staff • Provider NPI, license number and type, special experience, and gender • Accepting new patients, and ages seen • Hours of operation from Monday through Sunday	CalOptima VSP Contract, Sections: 1.17 7.1	Monthly: 15th of every month	X					X
Health Education Calendar - Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Calendar listing available classes. The report shall include, at a minimum: • Class or program name • Location • Date and time	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Health Education Individual Encounters-Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Individual Encounters listing CalOptima members who attended Kaiser Health Education classes or programs. The report shall include, at a minimum: • Class or program • Number of members in attendance	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Health Education Other Encounters - Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Other Encounters listing CalOptima members who attended Kaiser classes or programs. The report shall include, at a minimum: • Class or program • Number of members in attendance	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Perinatal Support Services	Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts.	CalOptima Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program	Monthly: 15th of every month	X				X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
(PSS) Encounters - Kaiser	The data include the following: • Member CIN • Member DOB • Estimated Delivery Date • Participating in CPSP (Y/N) • Date CPSP Initiated	DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 7							
Access and Availability Report - Kaiser	Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards. The report includes the following: • Analysis of availability of practitioners (primary care and specialty services, including BH services) against standards for access • Analysis of access to practitioners (primary care and specialty services, including BH services) against standards for access • Non-behavioral and behavioral health identification of gaps in network specific to geographic areas or types of practitioners or providers by using analysis related to members experience with network adequacy and analyzing requests for and utilization of out-of-network services • Identifying opportunities and prioritizing opportunities for improvement identified from analyses of availability, accessibility and member experience accessing network • Documenting at least one intervention and measure effectiveness of interventions (if applicable)	DHCS APL 20-003: Network Certification Requirements, Contractual Relationship and Delegation DHCS Proposed Annual Network Certification Policy Changes NCQA Standards, Network Management: Net 1B – 1D Net 2A – 2C Net 3A – 3C CalOptima Policy GG.1600: Access and Availability Standards CalOptima Policy MA.7007: Access and Availability Title 28, CCR, Sections: 1300.67.2 1300.67.2.1 1300.67.2.2 DHCS Medi-Cal Contract, Exhibit A: Attachment 6 Attachment 9 Cal MediConnect 3-Way Contract, Section 2 Title 42, CFR, Section 438.206-207	Annually: February 15	X				X	
Quality Improvement (QI) Evaluation (Previous Year) – Kaiser, VSP	Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review. The evaluation includes the following: • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • Trending of measures to assess performance in the quality and safety of clinical care and quality of service	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4	Annually: February 15	X				X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices	CalOptima VSP Contract, Section 4.2 NCQA Standards, Quality Improvement, QI7							
QI Program – Kaiser, VSP	Kaiser shall develop an annual QI program description and submit to CalOptima for review. The program includes description of the following: • The QI program structure • The behavioral healthcare aspects of the program • Involvement of a designated physician in the QI program • Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program • Oversight of QI functions of the organization by the QI Committee • Objectives for serving a culturally and linguistically diverse membership	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 CalOptima VSP Contract, Section 4.2 NCQA Standards, Quality Improvement, QI7	Annually: February 15	X				X	X
QI Work Plan – Kaiser, VSP	Kaiser shall report progress towards quality improvement program goals semi-annually. The QI work plan includes the following: • Yearly planned QI activities and objectives • Timeframe for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 CalOptima VSP Contract, Section 4.2 NCQA Standards, Quality Improvement, QI7	Semi-Annually: February 15 and August 15	X				X	X
QI Work Plan Current Year (Initial) – Kaiser, VSP	Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. The work plan includes the following: • Yearly planned QI activities and objectives • Timeframe for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 CalOptima VSP Contract, Section 4.2 NCQA Standards, Quality Improvement, QI7	Annually; February 15 (for new year)	X				X	X
Report of Findings and Actions Taken as a Result of QI Activities – Kaiser, VSP	Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities. The report includes the following, at a minimum: • Any action taken for medical disciplinary cause or reason (through Medical Board of California or respective Licensing Board actions) • An action taken by a Peer Review Body or other organization that results in filing of a 805 or 805.01 with Medical Board of California or appropriate licensing board/agency, and/or report with the National Practitioner Data Bank (NPDB)	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 CalOptima VSP Contract, Section 4.2 NCQA Standards, Quality Improvement, QI7	Quarterly	X				X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Authorization Utilization Report	Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable). The report includes the following: • Member name, Client Identification Number (CIN), and date of birth • Health Network name or number, and PCP name • Authorization tracking/case number • Authorization request date, approved date, effective date, and expiration date • Services requested (CPT code and description) • Diagnosis (ICD and description) • Services approved to (name of provider or health delivery organization) • Specialty of provider who is authorized for services • Whether claim was submitted and date claim was paid	DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1 CalOptima Health Network Contract, Sections: 7.1 7.11 CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting	Quarterly: Q3 2019 - February 15, 2020 Q4 2019 - May 15, 2020 Q1 2020 - August 15, 2020 Q2 2020 - November 15, 2020	X			X	X	
Dental Anesthesia Report	Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD). The report includes the following: • Member categories: age 21 and older without DD, age 21 and older with DD, age 20 and younger without DD, and age 20 and younger with DD • Reporting quarter by months: number of requests (dental general anesthesia), approvals, denials due to requested documentation not submitted, denials due to not meeting medical necessity criteria, and denials due to other reasons • Reasons for the other denials for dental general anesthesia • Dental general anesthesia reporting comments	APL 15-012: Dental Anesthesia Services - Intravenous Sedation and General Anesthesia Coverage CalOptima Health Network Contract, Sections: 7.1 7.11 CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting	Quarterly: 15th of the month after the end of the quarter	X			X	X	
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review. The UM Evaluation includes the following: • The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 and Attachment 5, Provision 5 NCQA Standards, Utilization Management, UM1	Annually: February 15	X	X	X	X	X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Other UM work plans and reports • Signature and date approved								
UM Program	Health Networks shall develop a UM program description and submit to CalOptima for review. The UM Program includes a description of the following: • Written description of the program structure • Involvement of a designated senior-level physician in UM program implementation, UM activities, supervision oversight and evaluation of UM program • Behavioral healthcare aspects of the program •The program scope and process used to determine benefit coverage and medical necessity • UM Program's role in the QI program, including how the delegate collects UM information and uses it for QI activities • Information sources used to determine benefit coverage and medical necessity • The Health Network annually evaluates and updates the UM program, as necessary	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5 NCQA Standards, Utilization Management, UM1	Annually: February 15	X	X	X	X	X	
UM Work Plan (ICE)	Health Networks shall report progress towards UM program goals semi-annually. The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person (s), titles, key findings and analysis and interventions must include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM Work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5	Semi-Annually: February 15 and August 15	X	X	X	X	X	
UM Work Plan Current Year (Initial)	Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/Under utilization and referral timeframe compliance work plan and reports	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5	Annually: February 15 (for new year)	X	X	X	X	X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved								
Out-of-Network (OON) Requests	Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type. The report includes the following: • Health Network name, and reporting quarter and year • Date of OON referral request, and referral authorization number • Member name and CIN • Specialist name, NPI, address, and specialty type • Reason for OON referral request: Provider not accepting new patients, provider or specialty not available in network, timely access to provider, or other reasons (explanation provided by Health Network) • Resolution status (approved, denied, pending)	APL 20-003: Network Certification Requirements, Network Certification Non-Compliance DHCS Medi-Cal Contract, Exhibit A, Attachment 9	Quarterly: January 25, April 25, July 25, October 25	X			X	X	
Kaiser WCM Claim Detail	Kaiser shall submit monthly report of WCM claims payment information. The report includes the following: • CalOptima claim number and line, Kaiser claim number) • Provider name, NPI and tax identification number • Member CIN and name • Claim subtype, bill type, dates of service, place of service, revenue and procedure codes, DRG code and pricing, diagnosis and units. • Kaiser amount billed and paid • CalOptima amount • Claim remittance code and description • Report month and fiscal year • Check date, number and amount	CalOptima Health Network Contract, Section 9.11 CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks	Monthly: 15th of every month	X				X	
Preclusion List Report for Member Notifications Only	Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima shall notice impacted members on behalf of all Health Networks. The report includes the following: • Line of business (OneCare, OneCare Connect) • Member name, CIN, date of birth, address, and language • Precluded provider name and NPI • Service type (health care services, health care items, or prescriptions) • Preclusion list impacted membership attestation	HPMS Memo, 11/2/18, Preclusion List Requirements Final Rule, Vol. 83, No. 73, April 2018	Monthly: 10th of every month	X	X	X	X	X	X
Directed Payments File	Health Networks shall submit monthly Directed Payment adjustment report for qualifying services. The report includes the following:	APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services	Monthly: 10th of every month	X			X	X	

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Claim line ID • Health Network ID, claim number, and claim line number • Member name, CIN, and date of service • Clean claim or encounter received date • Whether an adjustment and previous claim number • Rendering provider name and NPI • Billing provider name, NPI, and Tax ID • Billed CPT/HCPCS code and modifier (if applicable) • Provider billed amount, and whether contracted provider claim • Claim paid amount and adjustment code (if applicable) • Whether fee-for-service or capitated claim • Directed payment amount and paid date, and check or EFT transaction number • Reimbursement disposition (reserved for CalOptima use) • Optional fields (for unique identifiers/specific to HN to help with reconciliation)	APL 19-015: Proposition 56 Directed Payments for Physician Services APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations APL 20-013: Proposition 56 Directed Payments for Family Planning Services CalOptima Policy FF.2011: Directed Payments CalOptima Health Network Contract, Attachment E-2						
Kaiser WCM Rx Detail	Kaiser shall submit monthly report of WCM Rx payment information. The report includes the following: • Member CIN, date of birth, and MRN (assigned by Kaiser) • Pharmacy NPI and fill date • Prescriber NPI and prescription number • Generic Code Number (GCN), National Drug Code (NDC), and brand generic flag • Drug name, quantity, days of supply, and amount paid • Eligibility for Medi-Cal and CCS • Duplicate record indicator and load date	CalOptima Health Network Contract, Section 9.11 CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks	Monthly: 15th of every month	X				X	
FDR Compliance Attestation	The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation. The report includes the following: • Indicator for participation in CalOptima programs (Medi-Cal, OneCare, OneCare Connect and/or PACE) • Organization name • Applicability of General and HIPAA Compliance and FWA Training • Applicability of Compliance Plan and Code of Conduct Requirements • Authorized Signature, Name, Email and Date • Organization Name	CalOptima Policy: HH.2023: Compliance Training CalOptima Health Network Contract, Sections: 3.26 3.27 Compliance Program Guidelines, Section 50.3, Chapter 9 Medicare Managed Care Manual; 8/26/2008 HPMS Memo: Offshore Subcontractor data module in HPMS;	Initial upon contracting; Annually thereafter	X	X	X	X	X	X

Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
		9/20/2007 HPMS Memo: Sponsor activities performed outside of the United States; 7/23/2007 HPMS Memo: Sponsor activities performed outside of the United States.							
Claims Timeliness Report	Health Networks shall submit a monthly claims payment performance (timeliness) report. The report includes the following: • Health Network name, management company name and report preparer name, title and email. • The reporting year, quarter and month(s). • The number of paid, contested and member-denied claims. • The number of claims paid within timeliness requirements. • The number of unprocessed claims on hand. • The total number of all claims received • The number of emergency room (ER) claims paid, contested and denied. • The number of ER claims paid timely. • Certification signed by principal officer, including name, title, phone and email.	CalOptima Health Network Contract, Section 2.7.8 Kaiser HMO Contract, Section 2.3.8 CalOptima VSP Contract, Section 3.8	Monthly: 15th of every month Quarterly: January 30, April 30, July 30, October 30	X	X	X	X	X	X

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
20. Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives

Contacts
Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Candice Gomez, Executive Director, Program Implementation (714) 246-8849
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Actions
Regarding the Clinical Field Team Pilot Program (CFTPP) and Homeless Health Initiative (HHI) FQHC Expansion Pilot:

1. Extend both pilots through December 31, 2021; and

2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend contracts with Federally Qualified Health Centers (FQHCs) and FQHC Look-alikes providing services under CFTPP.

Background
CalOptima has launched various initiatives to provide clinical care for CalOptima Medi-Cal Members (Members) experiencing homelessness through a series of actions approved by the CalOptima Board of Directors (Board). Specifically, the Board has approved and allocated funding for CFTPP and HHI FQHC Expansion to provide urgent, primary, and preventive care for individuals experiencing homelessness, as follows:

Date	Action(s)
February 22, 2019	• Authorized establishment of a CFTPP • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the CFTPP • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to serve as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification request for further implementation details

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Date	Action(s)
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members: • Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health • (While the IGT 1 – 7 funds were available to provide enhanced benefits to existing CalOptima Medi-Cal members, the IGT 8 and FY 2018-19 operating funds are limited to providing CalOptima Medi-Cal members with covered, medically necessary Medi-Cal health care services. If used for any other purpose, the Department of Health Care Services will categorize these expenditures as part of CalOptima's administrative expenses.) Actions and contracts with FQHCs: • Ratified the implementation plan for the Board authorized CFTPP • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., and Korean Community Services, Inc, dba Korean Community Services Health Center, and Serve the People Community Health Center
August 1, 2019	Actions and contracts with FQHCs • Authorized expenditures of $135,000 from FY2019-20 Medi-Cal HHI from medical expenses to administrative expenses • Authorized the HHI FQHC Expansion Pilot • Authorized contract amendments with FQHCs and FQHC Look-alikes to participate in the HHI FQHC Expansion Pilot • Ratified contract amendment with Families Together of Orange County to participate in the CFTPP Actions for development of CalOptima Homeless Clinical Access Program (HCAP) • Authorized modification of the CalOptima Days quality improvement and incentive strategy to include HCAP for health care services in mobile units at, or in fixed clinical sites within, shelters or hotspots, including those FQHCs and FQHC Look-alikes participating in the CFTPP or HHI FQHC Expansion Pilot
March 5, 2020	Actions and contracts with FQHCs • Authorized extension of the CFTPP through December 31, 2020 and operational changes • Authorized extension of the HHI FQHC Expansion Pilot through December 31, 2020 • Authorized contract amendments with FQHCs and FQHC Look-alikes to extend participation in the CFTPP or HHI FQHC Expansion Pilot, as applicable
April 16, 2020	Actions for modification of CalOptima Homeless Clinical Access Program (HCAP) • Authorized modification of HCAP to include telehealth visits and on-call services through the CFTPP • Authorized expenditure of $1 million in provider incentives consistent with the modification of HCAP

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The current CFTPP and HHI FQHC Expansion pilot were extended until December 31, 2020 with the intent to develop sustainable programs to be effective on January 1, 2021. Since then there have been significant changes to the health care environment due to the COVID-19 pandemic. On February 27, 2020, the County of Orange declared a local health emergency related to COVID-19. On March 4, 2020, the Governor of California declared a State of Emergency. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus. Subsequently, various initiatives were implemented in Orange County to address the needs of individuals experiencing homelessness including, but not limited to:

- The opening of alternate congregate sites to support social distancing for individuals residing in a shelter;
- Implementation of Project Roomkey, a state supported initiative to prevent and mitigate the spread of COVID-19 by providing non-congregate shelter in hotel and motel rooms for sick and medically vulnerable individuals experiencing homelessness; and,
- Implementation of the Homekey Program, an initiative funded through a grant awarded by the California Department of Housing and Community Development to rapidly sustain and expand housing, which will be available for some individuals moving out of Project Roomkey sites as early as November 2020.

In addition, CalOptima and community health centers have collaborated to ensure continued health care access during the crisis. As flexibilities from Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) regarding telehealth services, the following modifications were incorporated into the CFTPP or HHI FQHC Expansion pilot:

- Telehealth was included as an additional mode to provide health care services;
- Outreach was conducted to inform referral agencies of continued on-call urgent care availability and telehealth as an option;
- The CalOptima HCAP was enhanced to support ongoing access by adding an incentive for on-call days, as well as inclusion of telehealth visits.

CalOptima and the community health centers continue to discuss changes to the current health care environment and develop solutions to improve access to care for our members experiencing homelessness during the COVID crisis and beyond.

Discussion

Since the onset of the COVID-19 pandemic, the need for health care services provided through the CFTPP or HHI FQHC Expansion pilot has fluctuated. Fluctuations are due to the temporary closure of referring agencies, reductions in the number of available beds at shelters as a result of social distancing, and elimination of availability of walk-in services at some community-based organizations. Additionally, health care services were made available at alternate congregate and Project Roomkey sites that housed individuals experiencing homelessness and at risk for or tested positive for COVID-19. Due to these contributing factors, when compared with the average weekly volume prior to the onset of the pandemic in March 2020, CalOptima experienced a 40% decline in referrals for services provided to individuals experiencing homelessness between April and October 2020.

As social distancing restrictions lessen and the alternate congregate and Project Roomkey sites wind

down, it is expected that the demand for services provided through the CFTPP and HHI FQHC Expansion pilot will increase. The timing and availability of community-based services, shelter beds, and outreach services as the county reopens is unknown. Additionally, it is unknown if regulatory flexibilities regarding how health care services can be delivered, like telehealth, will be extended. Given that there are unknown factors, CalOptima staff recommends extending both the CFTPP and HHI FQHC Expansion pilot until December 31, 2021. This will provide the time necessary to assess and compare program outcomes and impacts prior to and as a result of COVID-19, which will inform the development of a sustainable, ongoing program. CalOptima staff continue to collaborate with the community health centers, county, and referring agencies in the development of a sustainable program and will return to the Board regarding additional recommended actions as needed.

Fiscal Impact

Forecasted homeless related initiative expenditures related to the CFTPP and the HHI FQHC Expansion Pilot from January 1, 2021 through June 30, 2021, is included in the FY 2020-21 Operating Budget approved by the Board on June 4, 2020. Management will include expenses related to the period of July 1, 2021, through December 31, 2021, in the FY 2021-22 Operating Budget. A previous Board action on April 4, 2019, to Consider Actions Related to Delivery of Care for Homeless CalOptima Members, created a restricted Homeless Health Reserve in the amount of $100 million. Funding for the CFTPP and the HHI FQHC Expansion Pilot is included under this reserve.

Rationale for Recommendation

Extension of the pilots and contracts are recommended to continue this program to serve CalOptima Medi-Cal Members experiencing homelessness and allow time to determine and address long-term COVID-19 impacts. The initiatives are consistent with the Board-approved Guiding Principles and Strategic Plan as it relates to the health care needs of members experiencing homelessness.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Contracted Entities Covered by This Recommended Board Action
2. Board Action dated March 5, 2020, Authorize Actions Related to Homeless Health Care Pilot Initiatives
3. Board Action dated April 16, 2020, Authorize Modification to CalOptima Homeless Clinical Access Program Homeless Health Initiative in Response to COVID-19, which includes as
   - Attachment 1: Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
   - Attachment 2: Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
   - Attachment 3: Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
   - Attachment 5: Board Action dated August 1, 2019, Consider Actions Related to Homeless Health Care Delivery
   - Attachment 6: Board Action dated August 1, 2019 Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative

/s/ Richard Sanchez — *11/24/2020*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip cod
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
Share Our Selves Corporation	1550 Superior Ave	Costa Mesa	CA	92627
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Actions Related to Homeless Health Care Pilot Initiatives

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Regarding the Clinical Field Team Pilot Program (CFTPP):
   a. Extend the CFTPP through December 31, 2020 with operational changes as described herein;
   b. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend contracts to implement the described operational changes with Federally Qualified Health Centers (FQHCs) and FQHC Look-alikes providing services under CFTPP; and
2. Regarding the Homeless Health Initiative (HHI):
   a. Extend the HHI FQHC Expansion pilot through December 31, 2020 and continue to allow for reimbursement to participating FQHCs and FQHC Look-alikes directly for services provided to CalOptima Members via mobile health care units, in fixed locations at shelters, and at identified homeless hotspots; and
   b. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts/contract amendments with FQHCs and FQHC Look-alikes as necessary to implement such payments.

Background

CalOptima has launched various initiatives to provide clinical care for CalOptima Medi-Cal Members (Members) experiencing homelessness through a series of actions approved by the CalOptima Board of Directors (Board). Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	• Authorized establishment of a CFTPP • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the CFTPP • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to service as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification request for further implementation details
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members • Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76

	million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health Actions and contracts with FQHCs • Ratified the implementation plan for the Board authorized CFTPP • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Serve the People Community Health Center • Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
August 1, 2019	Actions and contracts with FQHCs • Authorized expenditures of $135,000 from FY2019-20 Medi-Cal HHI from medical expenses to administrative expenses • Authorized the HHI FQHC Expansion pilot • Authorized contract amendments with FQHCs and FQHC Look-alikes to participate in the HHI FQHC Expansion Pilot • Ratified contract amendment with Families Together of Orange County to participate in the CFTPP Actions for development of CalOptima Homeless Clinical Access Program (HCAP) Authorized modification of the CalOptima Days quality improvement and incentive strategy to include HCAP for health care services in mobile units at, or in fixed clinical sites within, shelters or hotspots, including those FQHCs and FQHC Look-alikes participating in the CFTPP or HHI FQHC Expansion Pilot

CalOptima has contracted with five FQHCs and/or FQHC Look-alikes, also referred to as community health centers, to provide CFTPP services.

- Central City Community Health Center
- Families Together of Orange County
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc, dba Korean Community Services Health Center
- Serve the People Community Health Center

The CFTPP was deployed on a phased in basis based on the community health centers' readiness. The community health centers currently provide on-call services in Orange County seven days a week. While capacity in the number of providers and on-call time availability has gradually increased since inception, collectively, between April and December 2019, through the CFTPP the following activity occurred:

- Receipt of 209 referrals from CalOptima Case Managers for outreach to Members expressing housing needs
- 1,302 face-to-face contacts with individuals experiencing homelessness
- Participation in five pre-enforcement engagements in Anaheim, Costa Mesa, Fullerton, Placentia and San Clemente
- 494 clinical field team dispatches
- 448 clinical field team visits conducted, of which 276 were CalOptima members
- 72 referrals to recuperative care

Additionally, through the HCAP, mobile services are regularly scheduled at shelters and other Orange County locations to provide primary and preventive services. To support additional participation in the HCAP, the HHI FQHC Expansion pilot was initiated. The HHI FQHC Expansion pilot allows new community health centers, in addition to those participating as CFTPPs, to seek reimbursement for services provided through a mobile unit, at a fixed shelter location, or identified homeless hotspot from CalOptima regardless of health network affiliation. The program has been operational for less than six months and outcome results are still being collected. Both the CFTPP and HHI FQHC Expansion pilot are set to end on March 31, 2020.

Discussion

Since the CFTPP was initiated in April 2019, modifications have been implemented in order to effectively operate the program and respond to Member needs. Because this has been a new pilot program, adjustments have been made as staff has gained more experience in coordinating services. For example, the following adjustments have been applied:

- Adding on-call services to facilitate documentation of recuperative care medical justification for recuperative care
- Referral sources for clinical field team services have been expanded. In addition, to the Orange County Health Care Agency Outreach & Engagement staff and CHAT-H nurses, referrals are also received from Homeless Emergency Assistance Program (HEAP) providers, shelter operators, city agencies, and other homeless service providers
- Mobile schedule shared with all community health centers to promote coordination among them, especially when referring a member to follow-up care

- In collaboration with the community health centers, add more flexibility to the community health centers on-call schedules including on-call hours adjusted to 8:30 a.m. to 4:30 p.m. to better align with demand and mitigate safety issues

In 2019, CalOptima's Homeless Response Team dispatched the clinical field teams 494 times resulting in 448 clinical visits in the community. The Homeless Response Team also manages and maintains the community health centers schedule at shelters and hot spots to support the HCAP. Members experiencing homelessness are receiving health care services where they are located including shelters and hot spots. Because of claims lag, data regarding patient compliance, outcomes, inpatient, emergency department visits, and other utilization are still being evaluated. As such, CalOptima staff recommends extending both the CFTPP and FQHC Expansion pilots until December 31, 2020. Extending the pilots will allow for additional time to monitor outcomes and gain additional operational experience in developing sustainable programs. Furthermore, the California Department of Health Care Services released the Medi-Cal Healthier California for All proposal which includes a new Enhanced Care Management (ECM) benefit and availability of in lieu of services. ECM and in lieu of services become effective January 1, 2021 and have the potential to significantly impact services provided to Members experiencing homelessness.

In addition to recommending an extension of the CFTPP, CalOptima staff recommends modifying program requirements to adjust the on-call hours to 8:30 a.m. to 4:30 p.m. and other changes to align with administrative billing practices and actual services provided in the community. CalOptima staff also recommends removing the requirement to provide mobile services at two scheduled locations in four hour increments two days a week from the CFTPP. Providing services at set locations is now included in the HCAP and monitoring similar services through two separate programs is administratively duplicative for both the contracted CFTPP community health centers and CalOptima, especially as new community health centers begin to provide services through the HCAP.

CalOptima staff continues to work in collaboration with the community health centers and referring agencies and, based on feedback, is considering additional operational model changes to enhance the sustainability of the program which include:

- Modifying the on-call schedule based on current demand to allow for more flexibility for clinicians to see patients in the office and mobile units;
- Staggering provider hours to support scheduling in office appointments before or after CFT or mobile unit on-call shifts;
- Expanding outreach and education to existing and potential referring agencies regarding the program, deployment hours (including weekend availability) to continue building and refining the program to serve more individuals; and
- Considering an after-hour deployment fee for on-call services.

CalOptima staff will return to the Board regarding any additional recommended modifications to the pilot programs.

Fiscal Impact

The recommended actions to extend the terms of the CFTPP and the HHI FQHC Expansion pilot from April 1, 2020, through June 30, 2020, is budgeted under homeless related initiative expenditures in the

FY 2019-20 Operating Budget approved by the Board on June 6, 2019. Management plans to include expenses related to the period of July 1, 2020, through December 31, 2020, in the FY 2020-21 Operating Budget.

Rationale for Recommendation

Extension and modification of the pilots and contracts are recommended to continue this program to serve Members experiencing homelessness. The initiatives are consistent with the Board-approved Guiding Principles and Strategic Plan.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal
6. Board Action dated August 1, 2019, Consider Actions Related to Homeless Health Care Delivery
7. Board Action dated August 1, 2019 Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative
8. Board Action dated December 5, 2019, Consider Approval of Homeless Health Initiatives Guiding Principles

/s/ Michael Schrader — *02/26/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868

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CalOptima
A Public Agency
Better. Together.

Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

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*

Current System of Care (Cont.)

- 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)
- 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

- 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

Immediate Response

- 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

Strengthened System of Care

- 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”)

Federal and State Guidance

- 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

Federal and State Guidance (Cont.)

- 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)

Activities in Other Counties

- 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

Considerations

- 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

Additional Considerations

- 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

Recommended Actions

- 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~~
- 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.)

- 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

CalOptima's Mission

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


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Homeless Health Care Update

Board of Directors Meeting

April 4, 2019

Michael Schrader

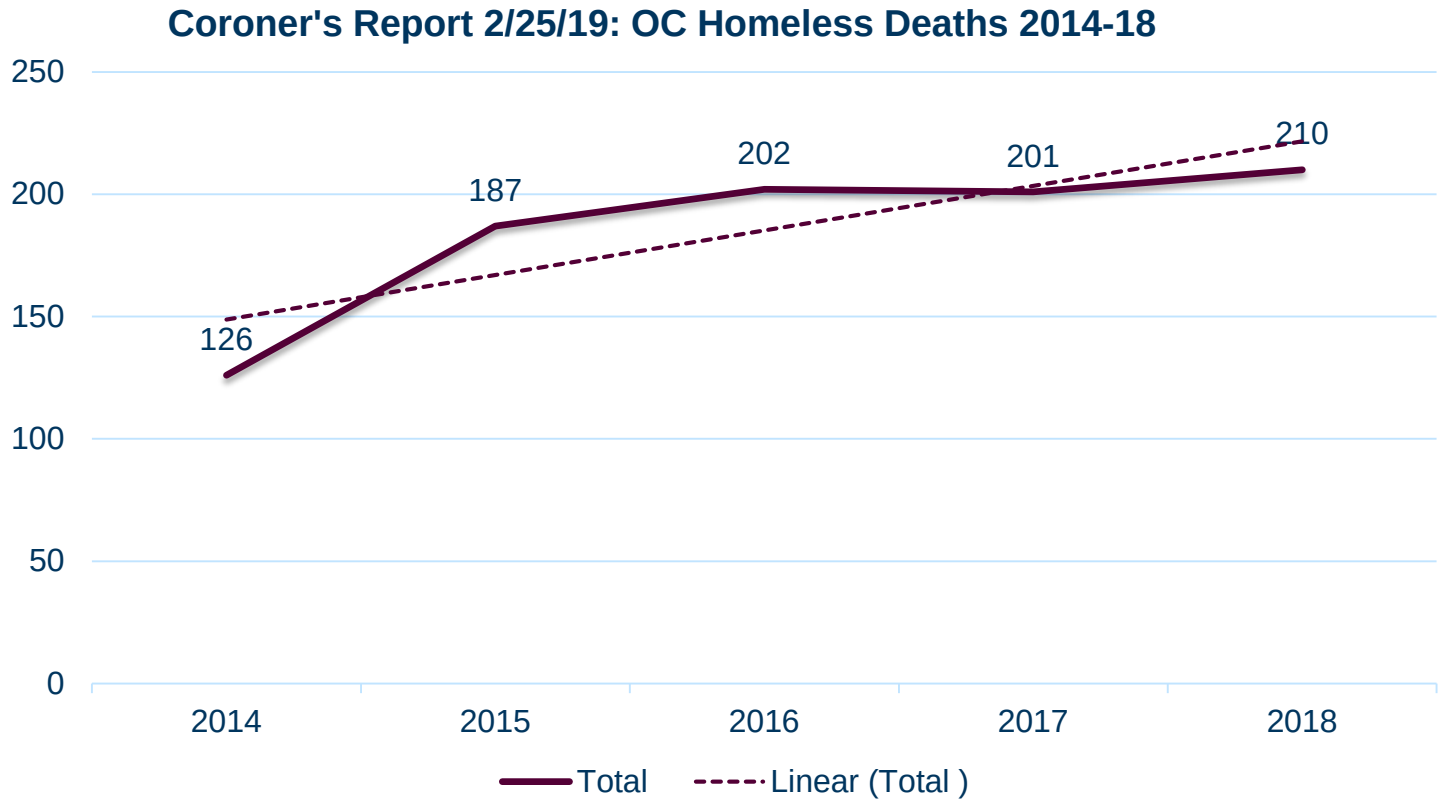
Chief Executive Officer

Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

Coroner’s Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
  - Clinical field teams (CalOptima)
  - CalOptima Homeless Response Team (CalOptima)
  - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
  - Opioid prescribing interventions (CalOptima)
  - Medication-assisted treatment (County and CalOptima)
  - Substance use disorder centers (County)
  - Medical detox (CalOptima)
  - Social model detox (County)
  - Naloxone (County and CalOptima)
  - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
  - Moderate-severe behavioral health (County)
    - Crisis intervention
    - Post-acute transitions
    - Intensive outpatient treatment programs
  - Mild-moderate behavioral health (CalOptima)
    - Screening
    - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee
Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

Ad Hoc Recommendations

- Take action to commit $100 million for homeless health
  - Create a restricted homeless health reserve
  - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$1.2 million	$4.8 million	IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)		$10 million	
New Initiatives		$60 million	
Total Reserve: $100 million	**$25.2 million**	**$74.8 million**	

Clinical Field Team Structure

- Team Components
  - Includes clinical and support staff
  - Vehicle for transportation of staff and equipment
  - Internet connectivity and use of Whole-Person Care (WPC) Connect
- Clinical Services
  - Urgent care, wound care, vaccinations, health screening and point-of-care labs
  - Prescriptions and immediate dispensing of commonly used medications
  - Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
  - Coordination with CalOptima Homeless Response Team
  - Coordination with providers
  - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
  - Regular hours at shelters/hot spots
  - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
  - AltaMed
  - Central City Community Health Center*
  - Hurtt Family Health Clinic*
  - Korean Community Services*
  - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
  - Deploy on a phased basis, based on FQHC readiness

** Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
  - Available to Blue Shirts and CHAT-H nurses
  - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
  - Establish working in-person relationships with collaborating partners
  - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
  - Maximum flexibility with access to any provider (no PCP assignment)
  - Fast-tracked authorization processing
  - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
  - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
  - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
  - $2 million financial impact per year
  - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
  - Reallocate $250,000 of the $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
  - Leverage existing process
    - County to coordinate and pay recuperative care vendor
    - CalOptima to reimburse County for 100 percent of cost
  - COBAR in April
  - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
  - Specifically used for homeless individuals
  - Includes social supports and referrals to services
  - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
  - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
  - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
  - Case management staff is trained and actively uses the system
    - Identify members enrolled in WPC
    - Coordinate with other partners caring for members
    - Access information from other partners

- Status of WPC Connect
  - Five hospitals are currently connected
  - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
  - Regulatory and legislative
  - Available permanent supportive housing and shelters
  - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
  - Enrollment assistance
  - Enhanced data connectivity technology
  - Housing supportive services
  - Other physical health services
  - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
  - Clinical field team implementation
  - Medical respite program
  - Homeless coordination at hospitals

- Additional action recommended by Board Ad Hoc
  - Create a restricted homeless health reserve in the amount of $100 million
    - $24 million – previously approved initiatives using IGT 1–7 funds
    - $76 million – all IGT 8 funds (approximately $43 million) with balance from FY 2018–19 operating funds
  - Stipulate that funds can only be used for homeless health

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as "homeless" based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima's ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to $1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

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Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to $1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in $320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- $500,000 from IGT 1 – Depression Screenings;
- $100,000 from IGT 6 – IS and Infrastructure Projects;
- $500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- $500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to $500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to $500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item
S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions
Authorize the $60 million identified for new homeless health initiatives as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Background
Supervisor Do is requesting consideration to allocate the $60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Attachments
1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do

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ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

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choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, $60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the $60 million allocated:

- **C**linic health care services in all homeless shelters - $10 million
- **A**uthorize mobile health team to respond to all homeless providers - $10 million
- **R**esidential support services and housing navigation - $20 million
- **E**xtend recuperative care for homeless individuals with chronic physical health issue-$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CalOptima
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June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of $100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately $100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved $60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - $10 million*
  As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - $10 million*
  Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - $20 million*
  The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - $20 million*
  CalOptima has twice allocated funds for recuperative care, bringing the total to $11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the "urgent" elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,

Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the $60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the $60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of $10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

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the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services "eventually" will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Actions Related to Homeless Health Care Delivery

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer to implement the following operational changes to support homeless health initiatives;
    a. Reallocate $135,000 in Fiscal Year (FY) 2019-20 Medi-Cal budgeted funds under homeless health-related initiatives from medical expenses to administrative expenses;
    b. Implement a pilot program to reimburse Federally Qualified Health Centers (FQHC) and FQHC Look-alikes directly for services provided via mobile health care units or in a fixed shelter location for dates of service from August 1, 2019 through March 31, 2020, based on the CalOptima Medi-Cal fee schedule and for eligible CalOptima Members notwithstanding health network assignment and continuing capitation payments;
    c. With the assistance of Legal Counsel, enter into contract amendments with FQHCs and FQHC Look-alikes providing mobile health care unit services; and
2. Ratify contract amendment with Families Together of Orange County effective May 17, 2019 to participate in the CalOptima Clinical Field Team pilot program providing health care services for homeless members at their locations and provide start-up funding.

Background
CalOptima has launched various initiatives for its Members experiencing homelessness through a series of CalOptima Board of Directors' actions. Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	• Authorized establishment of a Clinical Field Team pilot program • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the Clinical Field Team pilot programs • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to service as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification request for further implementation details • Obtain legal opinion related to using Medi-Cal funding for housing related activities
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members

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	• Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health Actions and contracts with FQHCs • Ratified the implementation plan for the Board authorized Clinical Field Team Pilot Program • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Service the People Community Health Center • Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
June 27, 2019	Authorized $60 million identified for new homeless health initiatives as follows: 1. Clinic health care services in all homeless shelters - $10 million 2. Authorize mobile health team to respond to all homeless providers - $10 million 3. Residential support services and housing navigation - $20 million 4. Extend recuperative care for homeless individuals with chronic physical health issue - $20 million

In addition to the above actions, a Board ad hoc committee focused on homeless health initiatives has engaged numerous community stakeholders, county agencies, providers, health networks, advocates, and other stakeholders to gather information regarding the needs of individuals experiencing homelessness and to make recommendations to the Board on how the health care needs of these members can best be met. The ad hoc's intent is to help develop a thoughtful, strategic approach to leveraging available CalOptima resources to meet the health care needs of homeless members. The overarching goal is to work collaboratively with community partners in developing a health care system that bridges individuals seeking urgently needed health care services where they are located to clinic and office-based settings, while utilizing the existing care management system.

Discussion

Operational changes to support homeless health initiatives

In order to implement the recommended actions, CalOptima staff will make the necessary operational changes and update policy and procedures and return to the Board for approval of any proposed changes to Board-approved policies. Additionally, authority is requested to add two unbudgeted FTE staffing resources, one Sr. Project Manager and one Sr. Program Manager, to support the operational

implementation and ongoing maintenance of homeless health initiatives in CalOptima's Case Management Department. Staff anticipates filling these proposed new positions in September 2019. The total estimated annual cost for the two impact is approximately $324,000, or $270,000 for the ten-month period from September 1, 2019, through June 30, 2020.

Implement pilot program for mobile health units and fixed clinic locations

Based on recent Board actions, CalOptima staff is in the process of expanding healthcare services options available to members experiencing homelessness, including access to preventive and primary services, at the shelter sites. CalOptima staff has also received stakeholder feedback that such services would be of value at other "hot spots," such as parks and soup kitchens. In a separate Board action, CalOptima staff is requesting consideration of modifying its quality improvement strategies, "CalOptima Days", to incentivize FQHCs and FQHC Look-alikes to provide health care services through their mobile units at shelters and other hotspots in the community. Additionally, some clinics are establishing fixed clinical sites within the four walls of the shelter. As proposed, the mobile clinics and fixed shelter locations will establish a regular schedule based on input from the shelters/hotspots, encourage CalOptima Members to seek services from their assigned CalOptima providers, and coordinate services with other medical and behavioral health care providers when appropriate. In order to better monitor utilization and coordination of services on a pilot basis, CalOptima staff recommends reimbursing the clinics for services provided in the mobile unit or fixed shelter location through CalOptima based on the CalOptima Medi-Cal fee schedule regardless of the Member's health network assignment for service rendered August 1, 2019 through March 31, 2020, to coincide with the Clinical Field Team pilot program. Through this process reimbursement will only be provided for Members eligible with CalOptima at the time services are rendered.

Ratify contract amendment with Families Together of Orange County

The Clinical Field Team pilot program is making available urgent care type medical services to Orange County's homeless Members onsite where they are located. This delivery model is designed to reduce delays in care that some homeless Members may experience, whether caused by unwillingness to access services in a typical office-based care setting, challenges with transportation or appointment scheduling, or other factors. Services provided at the Member's location also help prevent or reduce avoidable medical complications such as hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease. For the pilot program, CalOptima has engaged FQHCs (and FQHC Look-alikes) to provide medical services because they provide services to both CalOptima Members and non-CalOptima members; including those who are uninsured. Four community clinics were initially engaged to provide services under the Clinical Field Team pilot program. As indicated, on February 22, 2019, the Board allocated funds for start-up costs for the Clinical Field Team pilot program, resulting in approximately $320,000 in start up funding available per clinic for up to five clinics. Families Together of Orange County was contracted as the fifth provider effective May 17, 2019 and has been provided with start-up funding.

CalOptima staff recommends the Board authorize up to $300,000 from the $10 million allocated on June 27, 2019 towards "Clinic health care services in all homeless shelters" to provide funding for these payments through June 30, 2019. Similar to the Clinical Field Team pilot program, CalOptima will contract with FQHCs and FQHC Look-alikes operating mobile units to provide medical services to CalOptima Members. Reimbursement provided by CalOptima for services provided through the mobile units will apply to CalOptima members as FQHCs are able to obtain alternate funding sources for services provided to individuals not eligible with CalOptima. To be eligible to contract with

CalOptima, the mobile unit must meet Health Resources and Services Administration (HRSA) and CalOptima requirements.

Fiscal Impact

The recommended action to reimburse FQHCs and FQHC look-alikes for services provided in a mobile until for the period August 1, 2019, through March 31, 2020, is a budgeted item. Expenses of up to $300,000 for claims payments and up to $270,000 for staffing expenditures for two new positions is budgeted under homeless health related initiatives in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the "Clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

The recommended action to reallocate $135,000 in budgeted funds within the Medi-Cal line of business from medical expenses to administrative expenses for the Sr. Project Manager position is budget neutral. Staff will monitor the claims volume. To the extent there is an additional fiscal impact, such impact will be addressed in separate Board actions.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for CalOptima Members experiencing homelessness, CalOptima staff recommends these actions to facilitate increased access to services and ongoing operational and clinical support of the initiatives.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Presentation dated March 7, 2019, Homeless Health Update
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. CEO Report to the CalOptima Board of Directors dated May 2, 2019
6. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
APLA Health & Wellness	611 S Kingsley Dr	Los Angeles	CA	90005
Benevolence Industries Inc dba Benevolence Health Centers	1010 Crenshaw Blvd	Torrance	CA	90501
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Central City Community Health Center	1000 San Gabriel Blvd., Suite 200	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 260	La Habra	CA	90631
Hurtt Family Health Clinic, Inc	1 Hope Dr	Tustin	CA	92782
Korean Community Services Inc	8633 Knott Ave	Buena Park	CA	90620
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Development Corpration dba Livingstone Community Health Clinic	12362 Beach Blvd, Suite 10	Stanton	CA	90680
Mission City Community Network Inc	8527 Sepulveda Blvd.	North Hills	CA	91343
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Regional Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868
Serve the People, Inc. dba Serve the People Community Health Center	1206 E 17th St, Suite 101	Santa Ana	CA	92701

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Share our Selves Corporation	1550 Superior Ave	Costa Mesa	CA	92627
Southland Integrated Services Inc dba Southland Health Center	1618 W 1st St	Santa Ana	CA	92703
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
Vista Community Clinic dba VCC The Gary Center	1000 Vale Terrace Dr	Vista	CA	92084

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

Homeless Health Care Delivery

Board of Directors Meeting
March 7, 2019

Michael Schrader
Chief Executive Officer

Agenda

- Clinical field team pilot
- CalOptima Homeless Response Team
- Other expanded service options under consideration

Clinical Field Team Pilot

- Board approved up to $1.6 million in IGT 6/7 dollars for startup funding for a clinical field team (CFT) pilot of up to 1 year with Federally Qualified Health Centers (FQHCs)
- Develop parameters and structure for pilot program
  - Partner with up to five interested FQHCs that will:
    - Establish regular hours at high-volume shelters
    - Deploy to community locations on short notice
    - Coordinate to arrange for coverage with extended hours
    - Deliver urgent-care-type services to homeless individuals in need
      - Bill CalOptima for current CalOptima members
      - FQHCs to seek federal funding as payment for non-CalOptima members
- Staff working to complete contract amendments with FQHCs

Homeless Response Team

- Board authorized CalOptima Homeless Response Team
  - Eight new positions in Case Management department
  - Primary point of contact at CalOptima for homeless health services for CalOptima members
    - Dedicated phone line
    - Extended hours
  - Coordinate scheduling and dispatch of CFTs
  - Work closely with County, shelters and providers
    - Make regular field visits to shelters and recuperative care facilities providing services to CalOptima members
- Recruiting to fill positions

Expanded Service Options Under Consideration

- Embedded clinics at shelters
  - FQHCs to consider establishing regular hours for CFTs at selected high-volume shelters with deployment to other community locations on demand
- Whole-Person Care (WPC) hospital navigators
  - Increase per-diem and APR-DRG reimbursement to contracted hospitals for integrating into the WPC program
- Increased access to skilled nursing services
  - Deliver skilled services (e.g., home health nursing, physical therapy or IV antibiotics, etc.) at recuperative care facilities in lieu of skilled nursing facility placement

Expanded Service Options Under Consideration (cont.)

- Recuperative care beyond 90 days
  - Set up a post-WPC recuperative care program
  - Reallocate part of $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
    - From WPC recuperative care funds
    - To develop post-WPC recuperative care program
- Recuperative care with behavioral health focus
  - Coordinate with County to explore possibilities of:
    - Existing recuperative care facilities dedicating space for CalOptima members with underlying Serious Mental Illness (SMI)
    - Contracting with recuperative care vendor for a dedicated facility with behavioral health focus

Expanded Service Options Under Consideration (cont.)

- Housing supportive services
  - ➢ CalOptima could contribute Medi-Cal funding toward housing supportive services (not including rent) for certain CalOptima members under an 1115 waiver program
    - WPC
      - Link clients to other programs that provide housing supportive services
      - Amend County contract with the State to include a funding pool that CalOptima can contribute to for housing supportive services
    - Health Homes Program
      - For members with multiple chronic conditions who also meet acuity criteria (multiple ER visits, inpatient stays or chronic homelessness)
      - Members must elect to participate
      - Care management includes housing navigation

Expanded Service Options Under Consideration (cont.)

- Housing development and rental assistance
  - Obtaining legal opinion
  - Seeking guidance from the Department of Health Care Services

Next Steps

- Conduct further study on expanded service options under consideration, get feedback from stakeholders and return to Board for authority as appropriate on the following possibilities:
  - WPC hospital navigators
  - Increased access to skilled nursing services
  - Recuperative care beyond 90 days
  - Recuperative care with behavioral health focus
  - Housing supportive services
  - Housing development and rental assistance

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

Homeless Health Care Update

Board of Directors Meeting

April 4, 2019

Michael Schrader

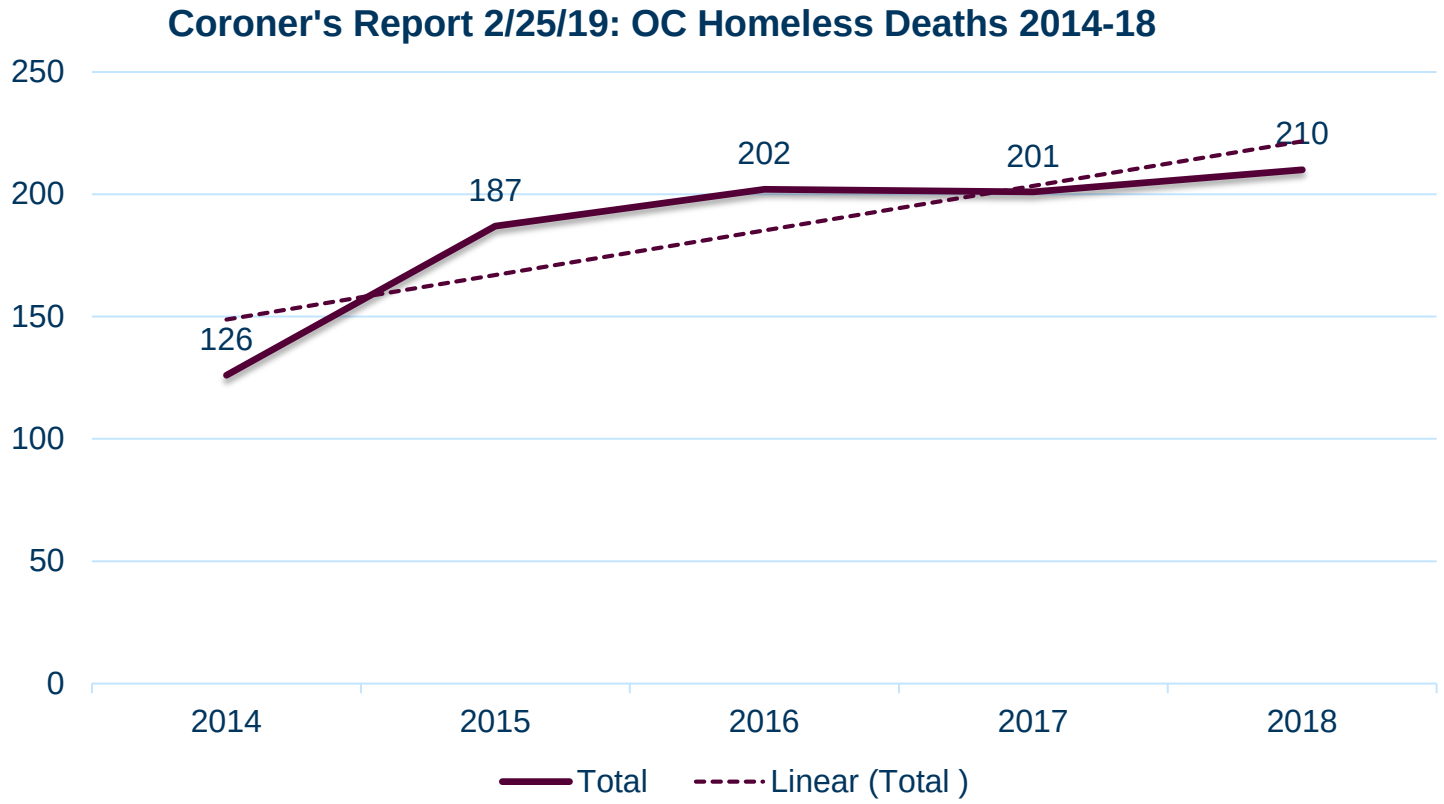
Chief Executive Officer

Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

Coroner’s Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
  - Clinical field teams (CalOptima)
  - CalOptima Homeless Response Team (CalOptima)
  - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
  - Opioid prescribing interventions (CalOptima)
  - Medication-assisted treatment (County and CalOptima)
  - Substance use disorder centers (County)
  - Medical detox (CalOptima)
  - Social model detox (County)
  - Naloxone (County and CalOptima)
  - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
  - Moderate-severe behavioral health (County)
    - Crisis intervention
    - Post-acute transitions
    - Intensive outpatient treatment programs
  - Mild-moderate behavioral health (CalOptima)
    - Screening
    - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee
Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

Ad Hoc Recommendations

- Take action to commit $100 million for homeless health
  - Create a restricted homeless health reserve
  - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$1.2 million	$4.8 million	IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)		$10 million	
New Initiatives		$60 million	
Total Reserve: $100 million	**$25.2 million**	**$74.8 million**	

Clinical Field Team Structure

- Team Components
  - Includes clinical and support staff
  - Vehicle for transportation of staff and equipment
  - Internet connectivity and use of Whole-Person Care (WPC) Connect
- Clinical Services
  - Urgent care, wound care, vaccinations, health screening and point-of-care labs
  - Prescriptions and immediate dispensing of commonly used medications
  - Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
  - Coordination with CalOptima Homeless Response Team
  - Coordination with providers
  - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
  - Regular hours at shelters/hot spots
  - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
  - AltaMed
  - Central City Community Health Center*
  - Hurtt Family Health Clinic*
  - Korean Community Services*
  - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
  - Deploy on a phased basis, based on FQHC readiness

** Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
  - Available to Blue Shirts and CHAT-H nurses
  - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
  - Establish working in-person relationships with collaborating partners
  - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
  - Maximum flexibility with access to any provider (no PCP assignment)
  - Fast-tracked authorization processing
  - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
  - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
  - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
  - $2 million financial impact per year
  - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
  - Reallocate $250,000 of the $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
  - Leverage existing process
    - County to coordinate and pay recuperative care vendor
    - CalOptima to reimburse County for 100 percent of cost
  - COBAR in April
  - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
  - Specifically used for homeless individuals
  - Includes social supports and referrals to services
  - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
  - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
  - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
  - Case management staff is trained and actively uses the system
    - Identify members enrolled in WPC
    - Coordinate with other partners caring for members
    - Access information from other partners

- Status of WPC Connect
  - Five hospitals are currently connected
  - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
  - Regulatory and legislative
  - Available permanent supportive housing and shelters
  - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
  - Enrollment assistance
  - Enhanced data connectivity technology
  - Housing supportive services
  - Other physical health services
  - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
  - Clinical field team implementation
  - Medical respite program
  - Homeless coordination at hospitals

- Additional action recommended by Board Ad Hoc
  - Create a restricted homeless health reserve in the amount of $100 million
    - $24 million – previously approved initiatives using IGT 1–7 funds
    - $76 million – all IGT 8 funds (approximately $43 million) with balance from FY 2018–19 operating funds
  - Stipulate that funds can only be used for homeless health

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner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Medi-Cal
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OneCare (HMO SNP)
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OneCare Connect
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PACE
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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as "homeless" based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima's ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to $1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

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Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to $1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in $320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- $500,000 from IGT 1 – Depression Screenings;
- $100,000 from IGT 6 – IS and Infrastructure Projects;
- $500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- $500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to $500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to $500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

MEMORANDUM

DATE:	May 2, 2019
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Homeless Health Initiatives Underway; Clinical Field Teams Launched in April

CalOptima moved our $100 million commitment to homeless health from concept into action this past month in several ways, most notably with the launch of clinical field teams. Guided by your Board's ad hoc committee, which is meeting weekly to spearhead the effort, selected initiatives are summarized below.

- Clinical Field Teams: Launched on time on April 10, CalOptima's first clinical field team conducted its first medical visit with a member at a Santa Ana park. Following a newly established process, the Orange County Health Care Agency's Outreach and Engagement team contacted our internal Homeless Response Team, which then dispatched a Central City Community Health Center (CCCHC) field team, consisting of a physician assistant and medical assistant. The field team treated a member needing care for a sizable open wound. CalOptima and CCCHC agree the initial experience was successful and instructive. Since that time, three other Federally Qualified Health Center (FQHC) partners have begun their programs, including Korean Community Services on April 17, Hurtt Family Health Clinic on April 18 and Serve the People on April 23. We are communicating with other FQHCs, directly and through the Coalition of Orange County Community Health Centers, about their potential participation in the clinical field team program. As we develop a better understanding of the population, its needs and the best methods for serving them, we will continue expanding our coverage.
- Anaheim Encampment: Reflecting our commitment to meeting the healthcare needs of members experiencing homelessness, CalOptima recently participated in a collaborative effort to clear a homeless encampment of approximately 70 people in 40 tents along a stretch of railroad tracks located in Anaheim. The group included the County's Outreach and Engagement team, the City of Anaheim, public health nurses, and other service providers. CalOptima arranged FQHC mobile clinics to work alongside the group to address any medical needs of the homeless. In addition, CalOptima had a case manager on site to make referrals.
- Use of Funds: Approximately $60 million of CalOptima's homeless health commitment is for new initiatives not yet identified. CalOptima is obligated to follow statutory, regulatory, and contractual requirements in determining the type of initiatives that are permissible. To that end, CalOptima has publicly shared the "Use of CalOptima Funds" document that follows this report. The information about the agency's framework and

allowable use of funds will ensure the community is aware of the principles guiding your Board's decision making regarding homeless health.

- Stakeholder Input: The Board ad hoc committee will be seeking additional input to our homeless health initiatives through meetings with stakeholders. CalOptima is in the process of identifying people and/or organizations to engage and will begin setting up those meetings. Recently, the ad hoc committee met with Former Santa Ana City Councilwoman Michele Martinez, Illumination Foundation CEO Paul Leon and Pastor Donald Dermit, from The Rock Church in Anaheim.
- State Programs and Legislation: Efforts to end the homeless crisis are ongoing statewide, and CalOptima is tracking a variety of bills and programs that have potential to positively impact Orange County. One example is the Housing for a Healthy California Program, which is a new source of funds for supportive housing through the Department of Housing and Community Development (DHCD). The program provides supportive housing for Medi-Cal members to reduce financial burdens related to medical and public services overutilization. DHCD is expected to open applications to supportive housing owners and developers for grants that total $36 million statewide. Orange County Health Care Agency intends to work with owners and developers to explore this funding opportunity. Separately, Assembly Bill 563 is state legislation that would grant the North Orange County Public Safety Task Force $16 million in funding to set up comprehensive crisis intervention infrastructure. The aim is to mitigate the local mental health and homeless crisis by expanding and coordinating the many available services, potentially through the Be Well OC Regional Mental Health and Wellness Campus. The bill is currently in the early stages of the legislative process.

Impact of New Knox-Keene Licensure Regulation Will Be Mitigated by Exemptions

With an effective date of July 1, 2019, a new Department of Managed Health Care (DMHC) global risk regulation will substantially expand the number of health care organizations required to have a Knox-Keene license. Fortunately, CalOptima was able to mitigate local concerns that the rule applied to our delegated health networks, which operate under three models — Health Maintenance Organizations (HMOs), Physician-Hospital Consortia (PHCs) and Shared-Risk Groups (SRGs). DHMC has now confirmed that CalOptima's limited Knox-Keene licensed HMO health networks may continue their current contractual arrangements with CalOptima, and the regulator has reached out to our partners to update their licenses. With regard to PHCs and SRGs, the DMHC has reviewed CalOptima's template contracts and believes that these limited risk-sharing arrangements will qualify for exemptions from the new licensure requirement. Contracts that renew or are amended after July 1, 2019, will need to be submitted to the DMHC for a review and exemption process that is anticipated to take no longer than 30 days. CalOptima staff has informed our health network partners about this latest positive development.

California Children's Services (CCS) Advisory Group Meeting Focuses on CalOptima Readiness for Transition

Implementation of the Whole-Child Model (WCM) for CCS in Orange County is now only two months away. Given our impending transition, CalOptima was the focus of an April 10 meeting of the CCS Advisory Group, a highly engaged Department of Health Care Services (DHCS)-appointed panel of medical experts and member advocates who are dedicated to ensuring the WCM effectively serves children with complex CCS conditions. CalOptima Chief Medical Officer David Ramirez, M.D., Executive Director of Clinical Operations Tracy Hitzeman and

Thanh-Tam Nguyen, M.D., our medical director for WCM, shared detailed information about our authorization process, provider panel, delegated delivery system and more, all from the member's perspective. Our WCM Family Advisory Committee Representative Kristen Rogers also spoke. The meeting was an important opportunity to instill confidence about our ability to effectively integrate the CCS program, and we successfully demonstrated CalOptima's careful preparations for WCM. Feedback from the advisory group and DHCS leaders was supportive.

Future Medi-Cal Expansion (MCE) Rates Face Likely Reduction as State Regulator Examines CalOptima Reimbursement

Following a trend established across the past few years, DHCS is signaling a likely reduction in CalOptima's MCE capitation rates for FY 2019–20. Staff was notified in April that a significant adjustment may be ahead, based on the fact that CalOptima's reimbursement for the MCE population is a noticeable outlier. Specifically, DHCS identified that CalOptima's provider capitation and risk pool incentive payouts are significantly higher than those paid by other managed care plans in California. Staff has been in close communication with state officials who will soon share our draft rates. Importantly, we are continuing to communicate with our provider partners so they can plan ahead for a possible reduction. As more information becomes available, staff will look to your Board's Finance and Audit Committee for guidance on any adjustments to provider reimbursement.

CalOptima Welcomes New Executive Director, Human Resources

This past month, Brigette Gibb joined CalOptima as Executive Director, Human Resources. She has more than 35 years of public-sector experience. Most recently, Ms. Gibb worked as the human resources director for the Orange County Fire Authority (OFCA), where she led and directed the administration, coordination and evaluation of all human resources and risk management functions. She has established and maintained effective working relationships with the OCFA Board of Directors, city managers, executive team members and labor group representatives. She holds a master's degree in public administration, with a concentration in human resources, from California State University, Fullerton.

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item
S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions
Authorize the $60 million identified for new homeless health initiatives as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Background
Supervisor Do is requesting consideration to allocate the $60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Attachments
1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

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choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, $60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the $60 million allocated:

- **C**linic health care services in all homeless shelters - $10 million
- **A**uthorize mobile health team to respond to all homeless providers - $10 million
- **R**esidential support services and housing navigation - $20 million
- **E**xtend recuperative care for homeless individuals with chronic physical health issue-$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CalOptima
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June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of $100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately $100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved $60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - $10 million*
  As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - $10 million*
  Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - $20 million*
  The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - $20 million*
  CalOptima has twice allocated funds for recuperative care, bringing the total to $11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the "urgent" elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,

Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the $60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the $60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of $10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

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the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services "eventually" will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative.

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality & Population Health Management, (714) 246-8400

Recommended Actions

1. Authorize modification of the existing "CalOptima Day" Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
2. Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
3. Authorize the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program.

Background

"CalOptima Day" is one of the Quality Improvement and incentive strategies approved by the Board on December 1, 2016 as part Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to $1.1Millon. CalOptima Day aims to increase access to care, enhance the member experience, and improve quality outcomes in collaboration with health networks and CalOptima Community Network provider offices. CalOptima Days are half- or full-day health and wellness events for high-volume provider offices or clinics chosen by health networks. Staff works with the provider office/clinic to schedule members to receive necessary preventive services on CalOptima Day. The provider office/clinic earns incentives for each completed preventive health visit, as evidenced by billing/encounter reporting using codes in accordance to the Healthcare Effectiveness Data and Information Set (HEDIS) specifications. The intent of these initiatives is to increase access to care and provide CalOptima members with immunizations, well-care visits and/or other services tied to quality measures. CalOptima Days have proven to be an impactful quality activity since they began in 2016. Due to the many benefits linked to CalOptima Days, they are now part of an ongoing quality strategy to improve access to preventive care and performance on quality measures.

During the February, April and June 2019 CalOptima Board meetings, the Board approved various homeless health initiatives, including an implementation plan for the Clinical Field Team Pilot Program (CFTPP) and contracts with Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes (jointly Community Health Centers) selected to participate in the CFTPP.

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As part of the CFTPP, CalOptima amended its contracts with five Community Health Centers to provide on-call services at hot spots throughout the county such as parks, encampments and shelters to address urgent clinical needs of individuals experiencing homelessness.

Further, the Board requested that CalOptima staff focus on significantly expanding preventive and primary care services at homeless shelter sites. CalOptima also received stakeholder feedback that such services would also be valuable at other hot spots, such as soup kitchens. CalOptima staff proposes expansion of the CalOptima Day model to provide greater access to preventive and primary care services at these locations in collaboration with interested Community Health Centers, whether they participate in CFTPP or not.

At its June 27, 2019 special meeting, the Board approved funding allocations for $60 million in new Homeless Health Initiatives. As part of this action, the Board allocated $10 million to "Clinic health care services in all homeless shelters."

Discussion

Staff recognizes the need for members experiencing homelessness to have reliable access to preventive and primary care in shelters and at other settings. Many shelters already have established relationships with community providers to provide those services via either an on-site or mobile clinic; however, hours may be limited. These services are sometimes not be billed, even when a provider is rendering services to a CalOptima member. This may occur, for example, if the provider is not contracted with the member's assigned health network or is not the member's assigned primary care provider (PCP). Further, some Community Health Centers have advised that set up and tear down of mobile clinics is time consuming and may not be cost-effective, even if the clinic is able to bill for the visit. These factors may contribute to limited access to care at shelters and other hot spots.

To address these concerns, CalOptima staff proposes partnering with any interested Community Health Centers to provide preventive and primary health care services at shelters and other hot spots. This may include locations that do not have established schedules with community providers, as well as those that may benefit from expanded schedules. These Community Health Centers will be required to create a regular schedule based on input from the shelters/hot spots, and those schedules will be informed by need, which may include bed count, frequency of resident turnover, other individuals served at the location, existing service schedules, and proximity to community providers. Additionally, the Community Health Centers will be expected to encourage CalOptima members to seek services from their assigned CalOptima providers and coordinate services with other medical and behavioral health care providers.

As proposed, and similar to the CalOptima Day tiered incentive payment model, clinics maintaining a presence at the shelter or hot spot will be compensated up to $1 million annually in total for all participating providers, excluding CalOptima staff resources, based on expanded hours and services completed for CalOptima members, as well as claims submission.

CalOptima staff proposes to offer eligible providers with a monetary incentive for participating in the HCAP according to two (2) tiers:

- Tier 1: An eligible provider will receive a Tier 1 provider incentive for event participation for a half day (4 hours) or a full day (8 hours).

- Tier 2: An eligible provider may receive a Tier 2 provider incentive, in addition to the Tier 1 provider incentive, if the following levels of services are provided:
    - Eligible provider completes 10 appointments during a half day (4 hours). Appointments may be any combination of well-care or vaccine-only visit.
    - Eligible provider completes 20 appointments during a full day (8 hours). Appointments may be any combination of well-care or vaccine-only visit.

Provider Incentive	Half Day (4 hours)	Full Day (8 hours)
Tier 1	$800	$1,600
Tier 2	$400	$800

Staff estimates that CalOptima will schedule a combination of 10 half day or full day HCAP events per week, with an average of 15 appointments completed during each event.

CalOptima staff will leverage the coordination and incentive mechanisms already established by the current CalOptima Day strategy. The effectiveness of CalOptima Days is measured by lead measures such as numbers of members accessing services, numbers of CalOptima Days with expanded hours, and lag measures such as HEDIS. A similar program measurement and evaluation discipline will apply to the HCAP.

In addition, management requests additional staffing to coordinate HCAP. Staff recommends the addition of two full-time equivalent positions: a Program Manager and a Quality Analyst. The total estimated annual impact of the addition of the two staff positions is approximately $231,087.

Fiscal Impact

The recommended action to develop HCAP by modifying the existing CalOptima Day Quality Improvement and incentive strategy is a Homeless Health Initiative budgeted item. Expenses of up to $1 million annually for provider incentives and $231,087 annually for staffing expenditures are budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget approved by the Board on June 6, 2019 and will be funded from the "clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

Rationale for Recommendation

CalOptima members experiencing homelessness sometimes face unique challenges in accessing the care they need. By partnering with shelters, other hot spots and Community Health Centers to implement the HCAP will help provide members with access to preventive and primary health services that this population segment may not otherwise seek. Early intervention while the members reside in shelters could also help them reacclimate to receiving scheduled care by appointment, hopefully helping to reintroduce them to obtaining health care in a more traditional and cost-effective setting.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Homeless Clinic Access Program Presentation
2. Board approval of Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to $1.1Millon. on December 1, 2016
3. CalOptima Day Fact Sheet

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

CalOptima Homeless Clinic Access Program

David Ramirez, M.D.
Chief Medical Officer

Betsy Ha, R.N., M.S., LSSMBB
Executive Director, Quality & Population Health Management

Building a Better System of Care

- In response to the homelessness crisis in Orange County, CalOptima has approved the following:
  - Homeless Response Team to coordinate care
  - Deployed the Clinical Field Team in collaboration with Federally Qualified Health Centers (FQHC) to provide urgent care for those unable or unwilling to access the traditional care system
  - Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination
  - Increased Recuperative Care funding and creation of a Medical Respite Program
- These initiatives focus on the urgent and clinical needs of members unsheltered.

Bridging to Existing System

Nontraditional Settings

- Clinical Field Teams (CFTs)
- Mobile Clinics
- Telehealth

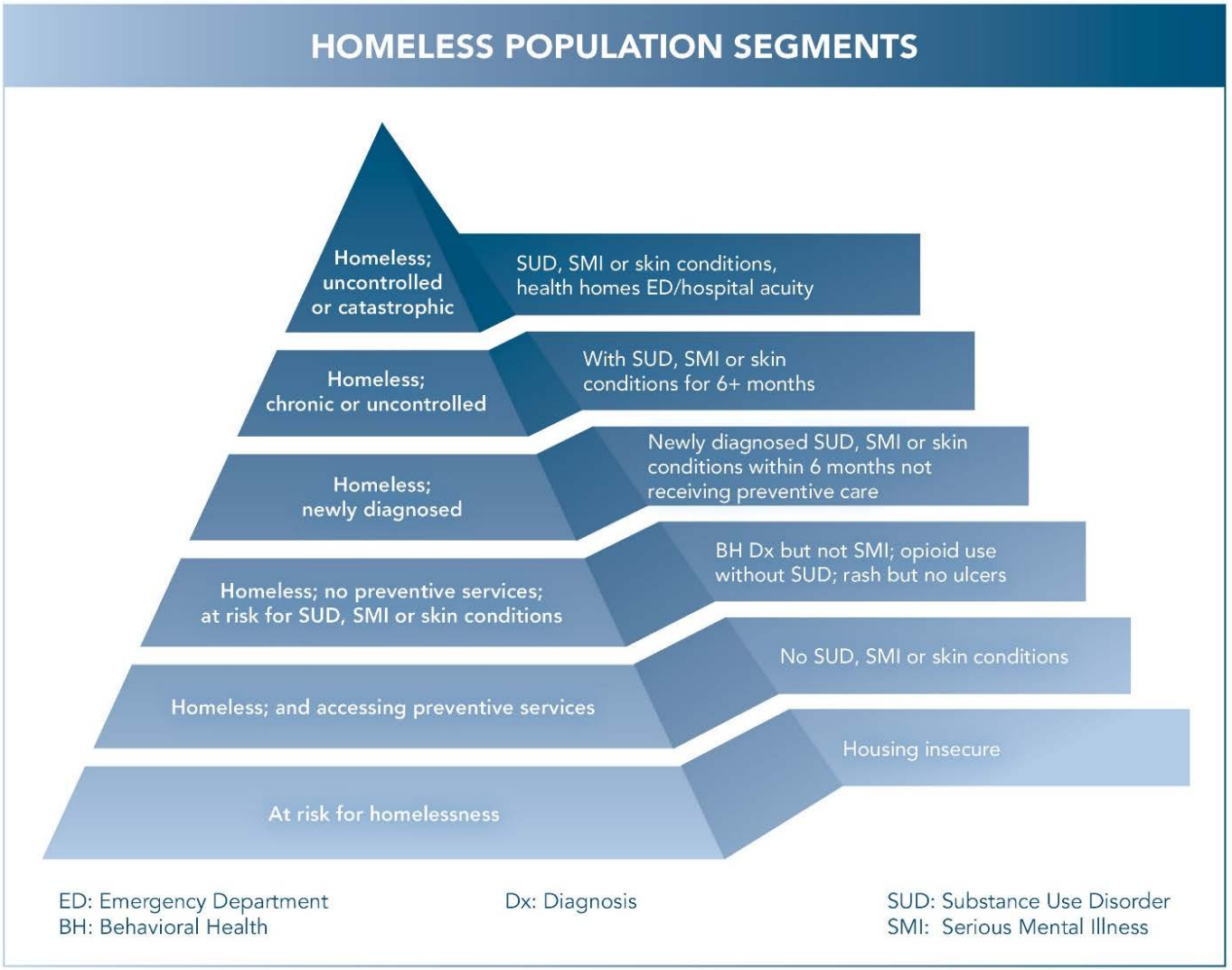
Transitional Settings

- Clinics in Shelters
- On-Site Supportive Services

Existing System

- Clinics
- Office-Based Providers
- Telephonic Case Management

A Population Health Approach



Clinic Health Care Services

- In response to the June 27, 2019, special meeting, the Board approved funding allocations of $60 million for new homeless health initiatives.
- As part of this action, the Board allocated $10 million to “Clinic health care services in all homeless shelters.”
- Staff recognizes the need to establish reliable, recurring, preventive and primary care schedules for members experiencing homelessness who are staying in shelters.
- Currently, most shelters in Orange County have inadequate physical health services available either on-site or through mobile clinics

Leveraging Quality Incentives

Modify the “CalOptima Day” Quality Improvement and incentive strategy for Homeless Health Initiative

Develop a CalOptima Homeless Clinic Access Program (HCAP)

Provide CalOptima Homeless Clinic Access Program (HCAP) at Orange County homeless shelters and other appropriate locations

What is CalOptima Day?

- A practice site-based Quality Improvement and incentive strategy used by CalOptima since 2016 to improve member access to care and HEDIS performance results
  - A half or full-day health and wellness event that is co-hosted by CalOptima, a health network, and a clinic or provider office, offering immunizations and well-care visits to our Medi-Cal members.
  - Clinic/providers offices' to only schedule appointments for CalOptima members assigned to the participating health network and clinic/provider office designated CalOptima Days.
  - Providers are incentivized to host the event and can receive up to $2,400 per CalOptima Day.
  - Members are incentivized with a $25 gift card for completing a visit.

2018 CalOptima Day Focused Measures

- Well-Care Measures
  - Well-Child Visits in the First 15 Months of Life (W15)
  - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
  - Adolescent Well-Care Visits (AWC)
- Immunization Measures
  - Childhood Immunization Status (CIS)
    - Combo 10
  - Immunizations for Adolescents (AWC)
    - Combo 2

CalOptima Homeless Clinic Access Program (HCAP)

- Increase the availability of preventive and routine health care services at Orange County shelters to create regular clinic schedules informed by need.
- Provide care transition support and encourage CalOptima members to seek services from their assigned CalOptima providers.
- Coordinate services with other medical and behavioral health care providers when needed.

Proposed Quality Measures

- Preventive services, screenings and chronic care HEDIS measures may include but not be limited to:
  - Access to Ambulatory and Preventive Care Services (AAP)
  - Adult BMI Assessment (ABA)
  - Chlamydia Screening (CHL)
  - Cervical Cancer Screening (CCS)
  - Adult Immunization Status (AIS)
  - Comprehensive Diabetes Care (CDC)
    - HbA1C
    - Retinal Eye Exam
    - Blood Pressure

Proposed Provider Incentives

- CalOptima will offer eligible providers a monetary incentive for participating in the CalOptima Homeless Clinic Access Program (HCAP) events according to two (2) tiers:
  - Tier 1: Eligible provider receives a Tier 1 incentive for event participation for a half (4 hours) or full day (8 hours)
  - Tier 2: Eligible provider may receive a Tier 2 provider incentive, in addition to Tier 1, if the following levels or service are provided;
    - Eligible provider completes 10 appointments during half day (4 hours)
    - Eligible provider completes 20 appointments during a full day (8 hours)

Provider Incentive	Half Day (4 Hours)	Full Day (8 Hours)
Tier 1 Incentive	$800	$1,600
Tier 2 Incentive	$400	$800

Fiscal Impact

- Expenses of up to $1 million annually for provider incentives and $231,087 annually for staffing expenditures
- Budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget
- Approved by the Board on June 6, 2019
- Will fund from the “Clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019

Staffing Expenditure

- Hire Program Manager and Quality Analyst
- Perform incentive program management
- Facilitate scheduling
- Provide care transition support
- Monitor quality and access to primary care
- Coordination with internal and external partners
- Quality performance measurement, analysis and reporting

Recommended Action

- Authorize modification of the existing “CalOptima Day” Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
- Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
- Authorize the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program.

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Approve the Quality Improvement activities listed on Attachment 1;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process;
3. Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1., subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and
4. Authorize unbudgeted expenditures not to exceed $1.1 million to implement these initiatives.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

One of the areas of focus within Quality Programs and Services is CalOptima's performance in the National Committee for Quality Assurance (NCQA) accreditation and ratings. The evaluation criterion for the NCQA health plan ratings consists of three dimensions: Prevention, Treatment and Member Satisfaction. According to the most recent NCQA Health Plan Ratings, (NCQA's Medicaid Health Insurance Plan Ratings 2015-2016) CalOptima scored 4 out of 5 on Prevention, 3.5 out of 5 on Treatment, and 2.5 out of 5 in Customer Service. Health Plans are rated on a 5 point scale. CalOptima achieved an overall rating of 4 out of 5. CalOptima has the distinction of being the top rated Medicaid Health plan in California for the past three years. CalOptima is proud to be the only California Medicaid health plan accredited at the "commendable" level by NCQA. Additionally, CalOptima has achieved a 3.5 out of 5.0 "STAR" rating for Medicare by the Centers for Medicare & Medicaid Services (CMS).

Although CalOptima has achieved much success in our quality programs, we have also identified two measures that were below the minimum performance level (MPL) established by the California

Department of Health Care Services (DHCS), and we have prospectively identified other quality measures on the decline that are required for NCQA accreditation and health plan ratings. In order to maintain or exceed our quality performance levels, it is imperative to consider additional interventions which are necessary to achieve these goals, as referenced in our 2016 QI Program Description (Clinical Data Warehouse section, pg 41). These include utilizing multiple levers (direct-to-member, direct-to-provider, incentives, communication strategies, etc.) and programs planned as ongoing strategies throughout the calendar year.

In preparing the CalOptima FY 2016-17 Operating Budget, staff applied the regular budgeting methodology which used the past year's actual run-rate assumptions to allocate funds to various categories, units and lines of business. Upon further review, it became clear that additional funding was necessary to meet existing program commitments for Medi-Cal quality monitoring, reporting and improvement as well as new and expanded quality programs.

Discussion

Maintaining CalOptima's "commendable" accreditation status and rating by NCQA as a top Medicaid plan in California requires ongoing investment in innovative quality initiatives focused on underperforming measures as well as measures aligned with NCQA accreditation, health plan ratings, as well as DHCS and CMS requirements. Funding is also requested to maintain current vendor contracts utilized for quality reporting and to support annually required trainings for quality staff.

Expenditures requested are classified as:

• Budget augmentation for current quality initiatives:	$ 457,740
• New requests for quality initiatives:	$ 605,839
Total Request	$1,063,579

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities provides additional detail on the quality related programs, initiatives and proposed incentives. Member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be fully developed and returned for Board approval prior to implementation, as well as regulatory approval, as applicable.

Fiscal Impact

The recommended action to appropriate and authorize expenditures of up to $1.1 million for Medi-Cal quality improvement and accreditation activities is an unbudgeted item. Management is requesting Board approval to authorize an additional amount of up to $1.1 million in medical expenses to fund the cost of the quality improvement activities.

Rationale for Recommendation

CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

Concurrence

Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer
Board of Directors' Quality Assurance Committee
Board of Directors' Finance and Audit Committee

Attachments

- Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
- PowerPoint Presentation: Quality Analytics Budget

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

11/22/2016 — **Date**

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

A. Budget Augmentation for Current Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Surveys & NCQA Fees	• Addition of CG CAHPs - Adult & Child • Fee increases for regular CAHPS • Implement SPD CAHPS • Additional record retrieval for Medical Record Review • Increase in NCQA required fees • Timely Access Survey	$252,937
NCQA Consultant	• RFP results did not produce viable option; completed bid exception for known entity due to timeframe	$17,375
Quality Initiatives in Flight	• Flu/pneumococcal shot reminders • Preventive care visits • Pharyngitis kits • Readmissions project (CMS QIP) • Member & provider communications (more non-adherent members; more measures to move) •	$138,793
	• Member and provider incentives	$12,380
Required Training	• Annual Inovalon & HEDIS Best Practices training • CME expenses for physician training • Provider education activities • New hire equipment	$28,480
Miscellaneous		$7,775
Total		**$457,740**

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

B. New Request for Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Member Programs	• Prenatal/postpartum incentive (Increase volume of outreach; $10,887 • Breast cancer screening -Downward trend Reminder mailing & incentive; $99,900 • Cervical cancer screening -Below MPL Reminder mailing & incentive; $149,900	$260,687
Provider Programs	• Physician office extended hours pilot project - MPL measures ($10,000) • Prenatal/postpartum provider office incentive ($5,000) • PCP office staff incentives for well women visits/screenings ($75,000) • Physician office extended hours initiative mailing ($2,500)	$92,500
Member Experience Initiatives	• Member focus groups, supplemental survey, provider CME ($72,525) • Practice coaches for member experience ($18,840)	$91,365
Provider Toolkits	• AWARE toolkit on antibiotic use ($5,000) • Provider Outreach/Education on AAB Measure (Below MPL; $1,500)	$6,500
Outreach Projects	• PSA for well women visits (Feb & May) - Culturally-specific radio stations ($99,900) • Child & Adolescent Outreach and Events for Childhood Immunizations (13% decrease; $44,887) • Educational posters/print ads for physician offices for Women's Wellness Campaign ($10,000)	$154,787
Total		**$605,839**

Quality Analytics Budget

Board of Directors' Quality Assurance Committee Meeting
November 16, 2016

Board of Directors' Finance and Audit Committee Meeting
November 17, 2016

Richard Bock, MD, Deputy CMO
Caryn Ireland, Executive Director, Quality

FY 2016-2017 Budget

- Budget augmentation for current quality initiatives: $457,740
  - Surveys & NCQA Fees
  - NCQA Consultant
  - Quality Initiatives in Flight
  - Required Training
  - Miscellaneous

- New requests for quality initiatives: $605,839
  - Member Programs
  - Provider Programs
  - Member Experience Initiatives
  - Provider Toolkits
  - Outreach Projects

Budget Augmentation for Current Quality Initiatives: $457,740

- Surveys & NCQA Fees: $252,937
  - Addition of CG CAHPS – Adult & Child
  - Fee increases for regular CAHPS
  - Implement SPD CAHPS
  - Additional record retrieval for Medical Record Review
  - Increase in NCQA required fees
  - Timely Access Survey
- NCQA Consultant: $17,375
  - RFP results did not produce viable option; completed bid exception for known entity due to timeframe
- Quality Initiatives in Flight: $151,173
  - Flu/pneumococcal shot reminders
  - Preventive care visits
  - Pharyngitis kits
  - Readmissions project (CMS QIP)
  - Member communications (more non-adherent members; more measures to move)
  - Member and provider incentives

Budget Augmentation for Current Quality Initiatives (cont.)

- Required Training $28,480
  - Annual Inovalon & HEDIS Best Practices training
  - CME expenses for physician training
  - Provider education activities
  - New hire equipment

- Miscellaneous $7,775

Funding for Additional Program: $605,839

- **Member Programs** — $260,687
  - Prenatal/postpartum incentive (Increase volume of outreach)
  - Breast Cancer Screening (Downward trend)
  - Cervical Cancer Screening (Below MPL)
- **Provider Programs** — $92,500
  - Physician office extended hours pilot project – MPL measures
  - Prenatal/postpartum provider office incentive
  - PCP office staff incentives for well women visits/screenings
  - Physician office extended hours initiative mailing
- **Member Experience Initiatives** — $91,365
  - Member focus groups, supplemental survey, provider CME
  - Practice coaches for member experience
- **Provider Toolkits** — $6,500
  - AWARE toolkit on antibiotic use
  - Provider outreach/education on AAB Measure (Below MPL)
- **Outreach Projects:** — $154,787
  - PSA for well women visits (Feb & May) – Culturally-specific radio stations
  - Child & adolescent outreach and events for childhood immunizations (13% decrease)
  - Educational posters/print ads for physician offices for Women's Wellness Campaign

Description of Additional Programs	Amount
Member Programs	$260,687
Prenatal/postpartum incentive (Increase volume of outreach)	$10,887
Breast cancer screening (Downward trend)	$99,900
Cervical cancer screening (Below MPL) - Reminder mailing and member incentives	$149,900
Provider Programs	$92,500
Physician office extended hours pilot project – MPL measures	$10,000
Prenatal/postpartum provider office incentive	$5,000
PCP office staff incentives for well women visits/screenings	$75,000
Physician office extended hours initiative mailing	$2,500
Member Experience	$91,365
Member focus groups ($50K), supplemental survey ($20,475), provider CME ($7K)	$72,525
Practice coaches for member experience	$18,840
Provider Tool Kits	$6,500
AWARE Toolkit on antibiotic use	$5,000
Provider outreach/education on AAB Measure (Below MPL)	$1,500
Outreach Projects	$154,787
PSA for well women visits (Feb & May) – Culturally-specific radio stations	$99,900
Child & adolescent outreach and events for childhood immunizations (13% decrease)	$44,887
Educational posters/print ads for physician offices for Women's Wellness Campaign	$10,000
Total	**$605,839**

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner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Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

QUALITY INITIATIVES

"CalOptima Day"
Child and Adolescent Health and Wellness Event

CalOptima strives to provide quality care for our members. This means finding new ways to better serve them. CalOptima is looking for health networks to host CalOptima Day, a one-day health and wellness event at one high-volume provider office or clinic of their choice, offering immunizations and well-care visits to children and adolescent Medi-Cal members.

Criteria for Participation:

- Health networks and the selected provider office or clinic will help market the event as "CalOptima Day."
- Voluntary participation of one provider office or clinic per health network that serves a high volume of targeted CalOptima Medi-Cal members in Orange County
- Provider office or clinic must be in good standing with CalOptima and have no sanctions or corrective action plans in place at the time of participation.
- Health networks and provider office/ clinic are expected to host a wellness event targeting any or all the measures listed: W15, W34, AWC, CIS and IMA.
- Provider offices and clinics are expected to conduct member outreach efforts including outbound calling, scheduling appointments and record keeping.
- Provider offices/ clinics and the health network are expected to properly code the office visit in accordance to the HEDIS specifications and provide validation to CalOptima this occurred.
- The participating provider or clinic shall provide feedback and a summary report of all vaccinations and well-child visits completed at the event.
- CalOptima will provide gift cards to members as incentives for receiving a recommended immunization(s) during the CalOptima Day event.
- CalOptima will offer participating provider offices or clinics a monetary incentive for hosting the health and wellness event of $300/hr. for each health event, up to $2,400/event. Depending on budget, a primary care provider (PCP)/clinic site may conduct more than one event at the discretion of CalOptima.

For more information, email questions to QI_Initiatives@CalOptima.org.

Please note: A limited number of provider offices and/or clinics will be eligible to participate in the Child and Adolescent Health and Wellness Event. Be on the lookout for more opportunities to participate in a CalOptima incentive program.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Approval of Homeless Health Initiatives Guiding Principles

Contact
Michael Schrader, Chief Executive Officer (714) 246-8400

Recommended Action
Approve Homeless Health Initiatives Guiding Principles and Crosswalk as a framework for future funding allocations.

Background
On April 4, 2019, the CalOptima Board of Directors committed expenditures of $100 million for Homeless Health Initiatives within a three-year period. At that time, $40 million was directed to a range of specific initiatives, including enhanced Medi-Cal services at the Be Well OC Regional Mental Health and Wellness Campus; recuperative care; clinical field team startup costs; CalOptima Homeless Response Team; and homeless coordination at hospitals. An additional $60 million was appropriated for future initiatives. At the special Board meeting on June 27, 2019, a proposal with funding allocations for the $60 million was approved. The funding allocations covered four areas: clinic health care services in all homeless shelters; authorize mobile health team to respond to all homeless providers; residential support services and housing navigation; and extend recuperative care for homeless individuals with chronic physical health issues. On September 5, 2019, staff received Board direction to develop Guiding Principles related to the $60 million allocation and to solicit input from Board members and providers on those principles.

The draft Homeless Health Initiatives Guiding Principles were shared with the Board on September 20, 2019, and a crosswalk of the Guiding Principles and funding categories was later integrated. Both documents were developed in coordination with the Board's ad hoc committee on homeless health. The draft Guiding Principles were also shared with the Orange County Medical Association, the Hospital Association of Southern California and CalOptima health networks. At the October 3, 2019, Board meeting, staff again received direction to bring the Guiding Principles to the full Board for consideration. On October 28, 2019, the California Department of Health Care Services released California Advancing and Innovating Medi-Cal (CalAIM), a proposal with the potential to significantly impact the future Medi-Cal delivery system framework, starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. On November 7, 2019, the Board requested that staff consider the impact of CalAIM on the Guiding Principles, update the document if needed and present the information to the full Board.

Discussion
The Board recognizes that the approved $60 million allocation for the Homeless Health Initiatives allows room for flexibility to execute the new initiatives that are most impactful and relevant to our

members experiencing homelessness. The staff developed the Homeless Health Initiatives Guiding Principles to refine the decision-making process, ensure investment in the most appropriate programs and to address provider concerns. Proposals consistent with the principles will be brought forward for consideration by the Board; proposals that are inconsistent will face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion on the allocation of funds. However, internal and external stakeholders will be able to use the Guiding Principles to support initiatives that unify the community around the shared goal of better serving Orange County's homeless population.

Fiscal Impact

The recommended action is budget neutral. The $60 million allocation has already been approved by the Board. The recommended action has the effect of distributing funds to various as yet undetermined initiatives, but the amount will not exceed $60 million.

Rationale for Recommendation

The above recommendation serves to guide funding allocations for CalOptima's Homeless Health Initiatives to ensure expenditures meet strategic priorities and have the most positive impact for members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Homeless Health Initiatives: Guiding Principles presentation
2. Homeless Health Initiatives Guiding Principles
3. Crosswalk: Guiding Principles and Homeless Health Funding Categories
4. CalAIM Appendix D

/s/ Michael Schrader *11/26/2019*
Authorized Signature Date

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Homeless Health Initiatives: Guiding Principles

Board of Directors Meeting
December 5, 2019

Michael Schrader, Chief Executive Officer
TC Roady, Director, Regulatory Affairs and Compliance
Candice Gomez, Executive Director, Program Implementation

Agenda

- Current initiatives and Board direction
- California Advancing and Innovating Medi-Cal (CalAIM)
- Homeless Health allocation in light of CalAIM

Current Initiatives

Board-Approved Programs With $100 Million Homeless Health Reserve	Funding
Be Well OC Regional Mental Health and Wellness Hub	$11.4 million
Recuperative Care	$10.75 million
Respite Care	$250,000
Clinical Field Team Startup	$1.6 million
CalOptima Homeless Response Team	$6 million
Homeless Coordination at Hospitals	$10 million
CalOptima Day and Quality Improvement Program	$1.2 million
Federally Qualified Health Centers Expansion	$.6 million
Total Allocated	**$41.8 million**
Remaining Funding Available	**$58.2 million**

- Other Board-Approved Programs Supporting Homeless Health
  - Medication-Assisted Treatment: $6 million (IGT funds)
- Other Programs Pending Board Approval
  - Housing Supportive Services: $2.5 million (reallocated from reserve)

Board Actions and Directives on Homeless Health

- In June, the Board adopted a $60 million allocation for homeless health spending in four categories
  - Clinic health care services in all homeless shelters
  - Mobile health team response to all homeless providers
  - Residential support services and housing navigation
  - Recuperative care for those with chronic physical health issues
- Working with the Board's ad hoc committee, staff developed Guiding Principles and crosswalk to provide the Board with a tool to guide funding decisions
- CalAIM has the potential to affect homeless health spending in the future
  - Consider CalAIM's impact on Guiding Principles

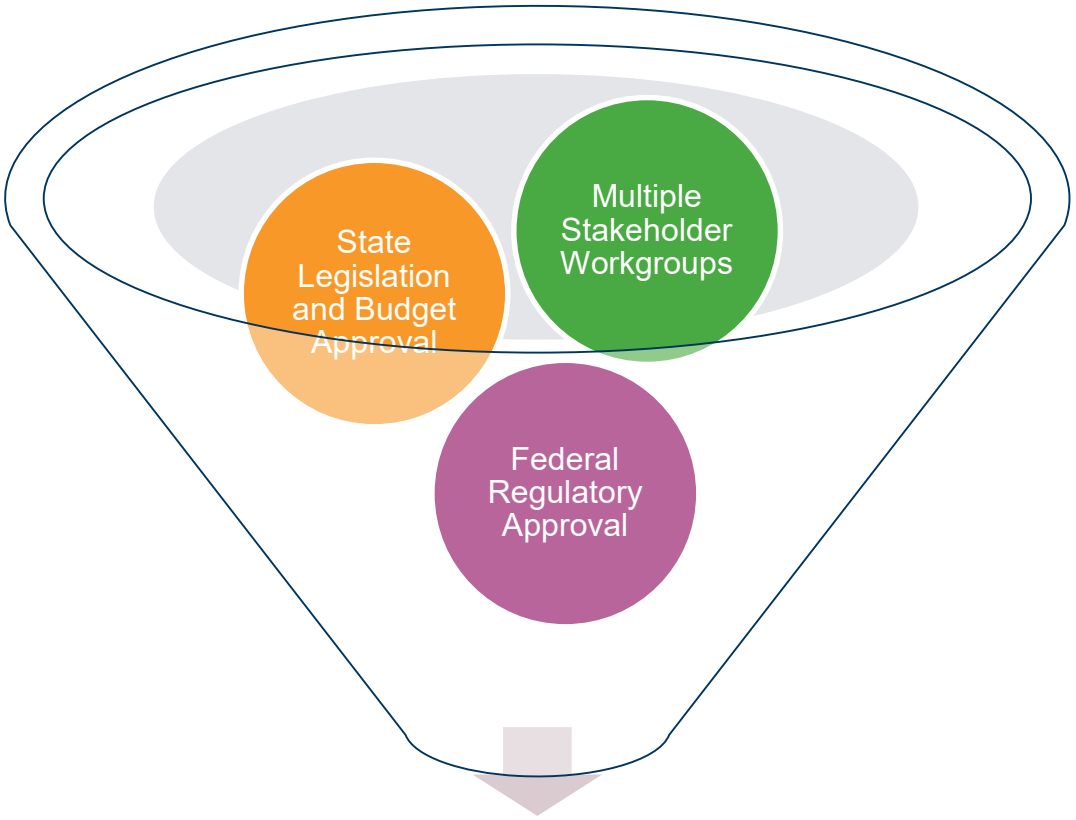
CalAIM Background

- On October 28, the Department of Health Care Services (DHCS) released CalAIM, a proposal with the potential to significantly impact the future Medi-Cal delivery system framework
  - Spans a five-year period from 2021 to 2025
  - Contains more than 20 core initiatives
  - Expands Medi-Cal managed care plans' responsibilities

- The proposal represents the start of a process that will include stakeholder engagement, and multiple federal and state approvals

CalAIM Process

- CalAIM is in the early stages of development
- CalAIM will evolve before reaching a final form for implementation starting January 1, 2021
  - ➢ Many layers of input will undoubtedly change the proposal



Final CalAIM Document

Five CalAIM Workgroups

Population Health/ Annual Enrollment	• Requires managed care plans to develop and maintain population health management strategies
Enhanced Care Management	• Explores implementation of an enhanced care management benefit and in lieu of services
Behavioral Health	• Considers integration of county-level mental health and substance use disorder programs
NCQA Accreditation	• Provides input on a proposal to require Medi-Cal managed care plans to obtain accreditation
Full Integration Plans	• Discusses full integration of physical health, behavioral health and oral health under one entity

Future CalAIM Implementation

- The various proposals have different effective dates, ranging from January 2021 to January 2025
  - Understanding the rules and regulations before and after implementation will be challenging

- With regard to CalOptima's Homeless Health Initiatives, three proposals (in their current form) have the most potential impact in the near term
  - Population Health Management
  - Enhanced Care Management
  - In Lieu of Services

Current State, Before CalAIM

- Programs that “bridge” to CalAIM
  - Health Homes Program (HHP)
    - Enhanced care management
    - Housing supportive services
  - Whole-Person Care (WPC)
    - Recuperative care
- Intergovernmental Transfer (IGT) 1–7 dollars
  - Enhanced services for Medi-Cal members
    - Reallocating funds toward housing supportive services
- IGT 8 dollars
  - Medi-Cal-covered services for Medi-Cal members
    - Enhanced hospital discharge planning
    - Transitions of care (under development with stakeholder group)

Future Possibilities, After CalAIM*

- Population Health Management (PHM)
  - Develop and maintain PHM programs compliant with NCQA requirements, and update and file annually with DHCS
  - Risk stratify populations (low-, medium- and high-risk) and have defined actions and programs to address population needs
  - Conduct initial member assessments and then reassessments on an annual basis
  - Offer basic, complex and enhanced care management

Subject to stakeholder input and CMS and DHCS approval

Future Possibilities, After CalAIM* (Cont.)

- Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
  - Statewide health plan benefit replacing HHP and WPC by January 1, 2021
  - Holistic, interdisciplinary approach to clinical and non-clinical needs of target populations
    - Individuals experiencing homelessness are specifically included as a target population
  - By July 2020, plans must submit transition plan moving from HHP and WPC to the ECM/ILOS model of care

Subject to stakeholder input and CMS and DHCS approval

Future Possibilities, After CalAIM* (Cont.)

- ILOS can only be covered if:
  - State determines that the service is a medically appropriate and cost-effective substitute for a typical service
  - The service is optional (beneficiaries are not required to use ILOS)
  - The service is authorized and identified in the state's Medi-Cal managed care plan contract

Menu of In Lieu of Services Options**
Housing transition navigation services
Housing deposits
Housing tenancy
Short-term post-hospitalization housing
Nursing facility transition/diversion
Recuperative care
Personal care and homemaker services
Respite care
Day habilitation programs
Home modifications
Meals/medically tailored meals
Sobering centers

***See CalAIM Appendix D for a detailed description of what is allowed under each of the above ILOS*

* *Subject to stakeholder input and CMS and DHCS approval*

CalAIM Advocacy

- California Association of Health Plans and Local Health Plans of California are actively participating in the CalAIM process
  - Managed care plans, including CalOptima, will be integral in shaping the eventual final CalAIM document
  - Managed care plans are generally very supportive of the direction CalAIM is headed

- Responding to the needs of Orange County's homeless population would be enhanced through adoption of certain current CalAIM proposals
  - CalOptima will advocate to this effect and pursue opportunities as available

Recommended Action

- Approve homeless health initiatives Guiding Principles and crosswalk as a framework for future funding allocations

HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES
December 5, 2019

Organizations across Orange County are actively responding to the local homeless crisis. CalOptima is participating by making improvements to the health care delivery system for homeless individuals. On April 4, 2019, the Board of Directors voted to commit $100 million in a restricted homeless health reserve. At that time, $40 million was directed to a range of specific initiatives, and $60 million was for unidentified new initiatives:

Projects *(as of April 4, 2019)*	**Allocated**	**Unallocated**	**Funding Category**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup Costs	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$6 million		IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)	$10 million		
New Initiatives		$60 million	
Total Reserve: $100 million	**$40 million**	**$60 million**	

In the months since, CalOptima has continued to consider program options, in part by welcoming input from community organizations and providers serving homeless individuals. On June 27, 2019, at a special Board meeting, the Board approved a proposal outlining $60 million in funding allocations for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers –$10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

The Board recognizes that the approved allocations allow room for interpretation and the possibility of executing new initiatives in various ways. Further, a recent state proposal, known as California Advancing and Innovating Medi-Cal (CalAIM), suggests significant changes to the Medi-Cal managed care landscape starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. To move forward with effective funding allocations in this dynamic environment, staff have developed Guiding

Principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns. Proposals consistent with the principles would be brought forward for consideration by the Board; proposals that are inconsistent would face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion, but internal and external audiences can use the principles to support initiatives that unify the community around our shared goal of better serving Orange County's homeless population.

GUIDING PRINCIPLES

Transparent and Inclusive

Inherent in CalOptima's response to the homeless crisis is a commitment to engage the community. Since beginning this effort and across several months, we have collaborated with Orange County Health Care Agency leaders, homeless advocates, community health center staff, provider representatives and countless others. CalOptima staff have and will continue to host meetings and forums, most recently adding a provider and hospital meeting series. Our interest in establishing these Guiding Principles starts from this place of inclusiveness.

- *CalOptima shall foster transparency in homeless health spending by regularly engaging stakeholders to gather ideas and feedback.*

Compliant and Sustainable

CalOptima has invested considerable time and money in understanding the legal and regulatory spending parameters related to health care delivery system enhancements for members who are homeless. In this environment, there are clear distinctions between funding sources that must be maintained. Intergovernmental Transfer (IGT) 1–7 dollars were permitted for enhancements to Medi-Cal services, but new IGT 8 dollars must be used according to different guidelines that restrict the spending to Medi-Cal-covered services. Furthermore, use of FY 2018–19 operating funds is similarly restricted to Medi-Cal-covered services for members, so expenditure of these dollars will be incorporated into CalOptima's rate development process. This would create sustainable funding for ongoing homeless health programs even after depletion of the Board-established homeless health reserve. However, the CalAIM proposal has the potential to expand Medi-Cal-covered benefits, which could broaden what CalOptima is permitted to fund for homeless health. This opportunity is under development, so until CalAIM is finalized, CalOptima must adhere to current rules. In any event, financial stewardship is one of CalOptima's core values, and our commitment is to spend on new homeless health initiatives in a fashion that complies with all applicable rules and appropriately builds our rates.

- *CalOptima shall spend the $60 million on allowable uses only, with the strict rule that IGT 8 and FY 2018–19 funds must be used for Medi-Cal-covered services for Medi-Cal members.*

Strategic and Integrated

CalOptima's effort to better serve members who are homeless is aligned with the strategic direction of state and federal regulators as well as industry trends. Population health initiatives recognize that certain populations need targeted interventions, and these programs can be integrated within the existing delivery system. For example, CalOptima's clinical field team program is designed to reconnect members with their medical homes not replace them. We appreciate the essential role of our hospital and health network partners and will purposefully seek ways to ensure new homeless health initiatives are integrated.

- *CalOptima shall support programs that honor the unique needs of the homeless population while integrating into the existing delivery system.*

Defined and Accountable

CalOptima is in new territory exploring ways to respond to the needs of homeless members. But our commitment to longstanding principles of quality and accountability has not changed. As we move forward, new programs will be carefully defined through Board-approved actions and subject to appropriate oversight and performance metrics. The CalOptima Board will hold itself accountable to ensure the implemented programs provide value and perform as anticipated, which may include establishing incentives for provider partners.

- *CalOptima shall identify measures of success and develop incentives to boost accountability in any new homeless health initiative.*

CROSSWALK: HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES AND FUNDING CATEGORIES

December 5, 2019

		Homeless Health Funding Categories			
		Clinic health care services in all homeless shelters	**Authorize mobile health team to respond to all homeless providers**	**Residential support services and housing navigation**	**Extend recuperative care for homeless individuals with chronic physical health issue**
Guiding Principles	**Transparent and Inclusive*** *Transparent planning that includes providers and other key stakeholders*	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: CalOptima and our health networks transparently and inclusively provide Medi-Cal members with case management and care coordination as appropriate. In addition, health networks will serve as CB-CMEs for HHP, with Illumination Foundation as an available vendor for housing navigation. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Separately, the IHSS, MSSP and PACE programs provide services in the member's home.	Consistent: Today, recuperative care is not currently a Medi-Cal benefit, apart from the WPC pilot to which CalOptima previously allocated funds for recuperative care. However, CalOptima is planning to advocate with providers and stakeholders through the CalAIM process for the state to make recuperative care a Medi-Cal benefit in 2021, upon the completion of the WPC pilot.
		*Assumes continued coordination of input from biweekly health network/hospital meetings with CalOptima Board Homeless Health Ad Hoc.			
	Compliant and Sustainable *Sustained Medi-Cal funding for CalOptima from DHCS*	Consistent: Continuing to pay for clinic services (Medi-Cal-covered services) for CalOptima Medi-Cal members at shelters would be sustainable in terms	Consistent: Continuing to pay for clinical field team services (Medi-Cal-covered services) for CalOptima Medi-Cal members would be sustainable in	Consistent: Case management and care coordination are covered benefits under the basic Medi-Cal program, and housing navigation is a	Inconsistent: Inconsistent today because recuperative care is not a Medi-Cal-covered service, except through the WPC pilot. Consequently, there

		of ongoing state funding.	terms of ongoing state funding.	covered benefit under HHP. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Consequently, there is sustainable funding within these parameters.	is no source of sustainable funding currently. However, the CalAIM process has the potential to broaden Medi-Cal-covered services to include recuperative care.
	Strategic and Integrated *Integration with CalOptima's contracted health care delivery system*	Consistent: Clinic services in homeless shelters should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Clinical field teams should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Case management and care coordination services are integrated into CalOptima's contracted health care delivery system. HHP CB-CMEs will also be integrated through health networks. The CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be integrated into the CalOptima system.	Consistent: If recuperative care becomes a Medi-Cal benefit following completion of the WPC pilot and/or implementation of CalAIM, CalOptima would integrate the benefit with our contracted delivery system of health networks and hospitals.
	Defined and Accountable *Specific deliverables and measures of success*	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: There is definition and accountability for health networks related to case management, care coordination and HHP CB-CME housing services. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be defined and accountable.	Consistent: If recuperative care becomes a Medi-Cal benefit, we will continue what the WPC pilot successfully started, including to have specific deliverables and measures of success (e.g., transitions to PSH).

Acronyms:
CalAIM = California Advancing and Innovating Medi-Cal
CB-CME = Community-Based Care Management Entity
HHP = Health Homes Program
IHSS = In-Home Supportive Services
MSSP = Multipurpose Senior Services Program
PACE = Program of All-Inclusive Care for the Elderly
PCP = Primary Care Physician
PSH = Permanent Supportive Housing
WPC = Whole-Person Care

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020
Special Meeting of the CalOptima Board of Directors

Report Item

2. Consider Authorizing Modifications to the CalOptima Homeless Clinic Access Program (HCAP) Homeless Health Initiative in Response to COVID-19.

Contact

David Ramirez, MD, Chief Medical Officer (714) 246-8400

Recommended Actions

1) Authorize modification of the existing Homeless Clinic Access Program (HCAP) for Homeless Health Initiative to include:
   a) Telehealth visits;
   b) On-call services provided through the Clinical Field Team Pilot Program (CFTPP); and
2) Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed modification to the HCAP.

Background

CalOptima staff has launched various initiatives to provide clinical care for CalOptima Medi-Cal Members (Members) experiencing homelessness through a series of actions approved by the CalOptima Board of Directors (Board). Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	• Authorized establishment of a CFTPP • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the CFTPP • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to service as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification requests and further implementation details
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members: • Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health Actions and contracts with Federally Qualified Health Centers (FQHCs):

	• Ratified the implementation plan for the Board authorized CFTPP • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Serve the People Community Health Center • Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
August 1, 2019	Actions and contracts with FQHCs: • Authorized allocation of expenditures of $135,000 from the FY2019-20 Medi-Cal Health Homes Initiative (HHI) budget from medical expenses to administrative expenses • Authorized the HHI FQHC Expansion pilot • Authorized contract amendments with FQHCs and FQHC Look-alikes to participate in the HHI FQHC Expansion Pilot • Ratified contract amendment with Families Together of Orange County to participate in the CFTPP Actions for development of CalOptima Homeless Clinical Access Program (HCAP) Authorized modification of the CalOptima Days quality improvement and incentive strategy to include HCAP for health care services in mobile units at, or in fixed clinical sites within, shelters or hotspots, including those FQHCs and FQHC Look-alikes participating in the CFTPP or HHI FQHC Expansion Pilot
March 5, 2020	• Authorized extension of the CFTPP through December 31, 2020 • Authorized amendments of the CFTPP contracts with operational changes • Authorized extension of the HHI FQHC Expansion Pilot through December 31, 2020 and amendment to contracts to implement the extension

On January 31, 2020, the Secretary of the U.S. Department of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On February 27, 2020, Orange County declared a local health emergency. 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.

On March 11, 2020, the Orange County Health Care Agency provided recommendations for COVID-19 community mitigation strategies. While social distancing has been encouraged to limit the spread of COVID-19, beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to prohibit professional, social, and community gatherings outside of a list of "essential activities." Subsequently, the Centers for Medicare & Medicaid Services (CMS) announced that all elective surgeries, non-essential medical, surgical, and dental procedures are to be delayed during the pandemic. Additionally, in order to continue to ensure access to necessary medical care for Medi-Cal enrollees, the Department of Health Care Services (DHCS) released emergency guidance regarding telehealth.

Discussion

Under the current HCAP, CalOptima offers eligible community health centers a monetary incentive according to two (2) tiers:

- Tier 1: An eligible community health center receives a provider incentive for event participation for a half day (4 hours) or a full day (8 hours).

- Tier 2: An eligible community health center receives a provider incentive, in addition to the Tier 1 provider incentive, if the following levels of services are provided:
    - Eligible provider completes 10 appointments during a half day (4 hours). Appointments may be any combination of well-care or vaccine-only visits; or
    - Eligible provider completes 20 appointments during a full day (8 hours). Appointments may be any combination of well-care or vaccine-only visits.

Due to the rapid spread of COVID-19, CalOptima staff has worked in partnership with the Orange County Health Care Agency (OC HCA) and the community health centers participating in the CFTPP to provide needed care to CalOptima members experiencing homelessness. OC HCA is establishing additional temporary shelters and partnering with motels to house individuals who are experiencing homelessness and are also at high risk, exhibiting flu-like symptoms, or have tested positive for COVID-19. The CFTPP will be relied upon to provide needed health care services for individuals at these locations. Under the current program design, on-call visits provided by the CFTPP are not eligible for HCAP incentives.

To support the community effort to provide care for individuals experiencing homelessness including those with COVID-19, Staff recommends expanding the current HCAP to include CFTPP scheduled on-call days. While start-up funds were initially provided to the community health centers participating in

the CFTPP, these funds were exhausted after the first year and the program is not sustainable for the community health centers to continue based on a per service reimbursement alone. The current HCAP criteria provides incentives to community health centers for providing health care services for a defined time period at a fixed location on a prescheduled basis. Expanding the HCAP will provide incentives to participating CFTPP community health centers for on-call services for a defined time period provided throughout the county, while encouraging the use of telehealth when possible and appropriate.

Staff recognizes the need for members experiencing homelessness to have reliable access to health care services where they are located and recommends including telehealth visits as part of HCAP, including the Tier 2 criteria to reduce the spread of COVID-19, exposure of healthcare staff to COVID-19. The use of telehealth visits will be in accordance with the CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services as well as the DHCS All Plan Letter (APL) 19-009 Supplement: Emergency Telehealth Guidance – COVID-19 Pandemic. During the national health emergency, telehealth visits will be the preferred visit type when clinically appropriate and feasible in an effort to avoid face-to-face contact to reduce the spread of COVID-19. Any non-public communication modalities including the telephone may be used for telehealth visits as authorized by DHCS and CMS. In order for those experiencing homelessness to have a telehealth visit, they would need to have access to a telephone. While providers will seek member consent to a telehealth visit, the Governor has issued an order relaxing the State statutory consent requirements for the COVID-19 crisis. Any individuals who decline telehealth visits will continue to be offered in person visits. In accordance with federal guidance, public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) are also not permissible for Telehealth.

CalOptima staff will continue to leverage the coordination and incentive mechanisms already established by the current HCAP. The effectiveness of program is measured by lead measures such as the number of members accessing services, the number of days with expanded hours being offered, and lag measures such as HEDIS, although CalOptima staff anticipates that some of the HEDIS measures or criteria may be modified due to the pandemic.

Fiscal Impact

The recommended action to expand Tier 2 provider incentives to include telehealth visits completed by an eligible provider under the HCAP will not have an additional fiscal impact. Staff anticipates that Homeless Health Initiative budgeted funds approved by the Board on August 1, 2019, for provider incentives will be sufficient to cover expenses related to the telehealth visit expansion.

The recommended action to expand Tier 1 provider incentives to include scheduled on-call days provided through the CFTPP is a Homeless Health Initiative budgeted item. Staff estimates costs of up to $1 million for the period of April 1, 2020, through December 31, 2020. Current year expenses are budgeted under homeless health-related initiatives in the FY 2019–20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the “clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019. Management will include expenses related to the CFTPP for the period beginning July 1, 2020, in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

CalOptima members experiencing homelessness sometimes face unique challenges in accessing the healthcare services they need. By partnering with shelters, other hot spots, and Community Health Centers to implement the HCAP, CalOptima staff plans to help ensure that members experiencing homeless have access to preventive and primary health services—services that this population segment may not otherwise seek or be able to obtain. Early intervention while the members reside in shelters could also help them reacclimate to receiving scheduled care by appointment, hopefully helping to reintroduce them to obtaining health care in a more traditional and cost-effective setting.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
3. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
4. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal
5. Board Action dated August 1, 2019, Consider Actions Related to Homeless Health Care Delivery
6. Board Action dated August 1, 2019 Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative
7. Board Action dated December 5, 2019, Consider Approval of Homeless Health Initiatives Guiding Principles
8. Board Action dated March 5, 2020, Consider Actions Related to Homeless Health Care Pilot Initiatives
9. March 19, 2020 CMS Announcement: COVID-19 Elective Surgeries and Non-Essential Procedures Recommendations
10. GG.1665: Telehealth and Other Technology-Enabled Services
11. DHCS All Plan Letter 19-009: Emergency Telehealth Guidance – COVID-19 Pandemic
12. Executive Order N-43-20

/s/ Richard Sanchez *04/10/2020*

Authorized Signature **Date**

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

Back to Agenda Back to Item

Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Current System of Care

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*

Current System of Care (Cont.)

- 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)
- 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

- 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

Immediate Response

- 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

Strengthened System of Care

- 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")

Federal and State Guidance

- 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

Federal and State Guidance (Cont.)

- 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)

Activities in Other Counties

- 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

Considerations

- 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

Additional Considerations

- 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

Recommended Actions

- 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~~
- 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.)

- 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

CalOptima's Mission

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


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Homeless Health Care Update

Board of Directors Meeting

April 4, 2019

Michael Schrader

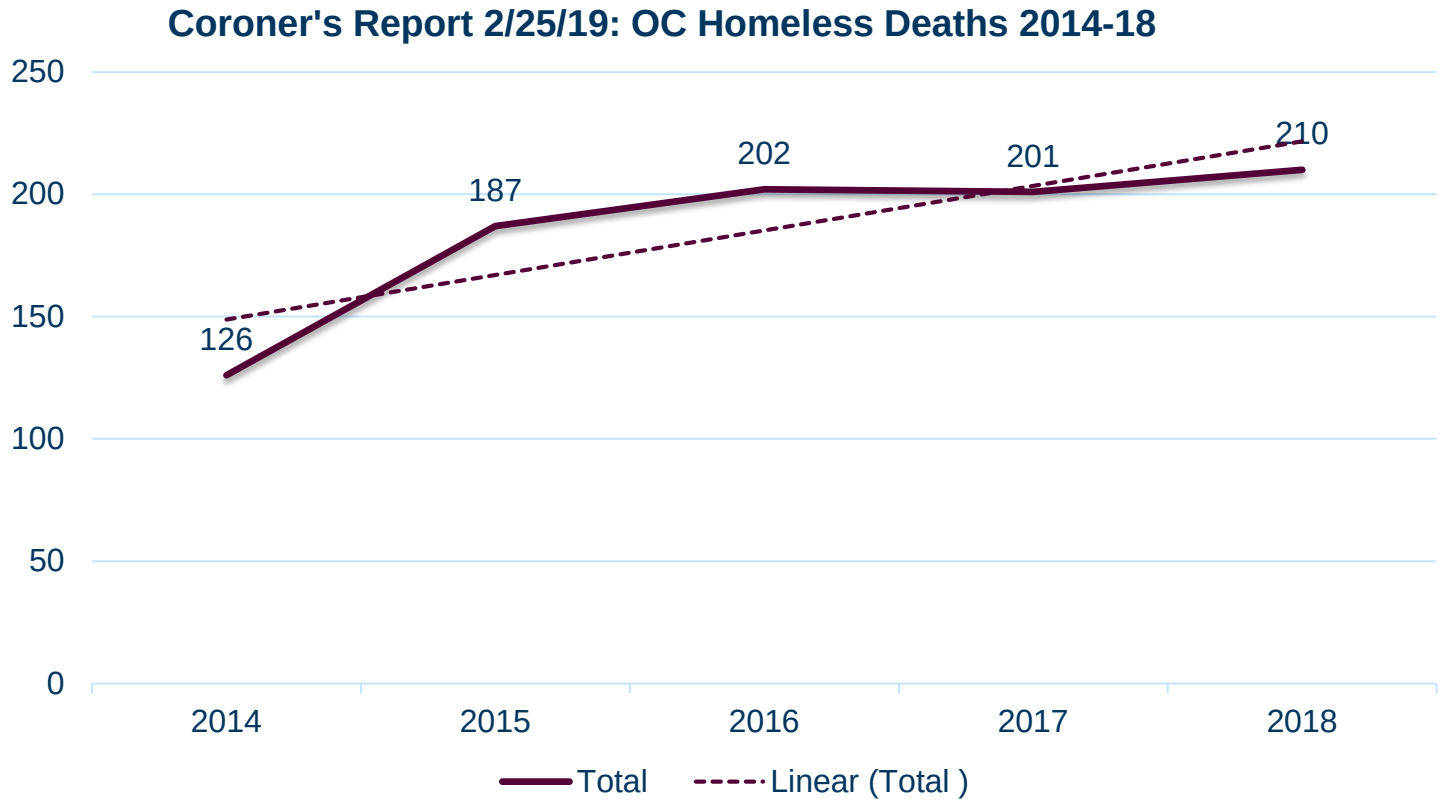
Chief Executive Officer

Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

Coroner’s Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
  - Clinical field teams (CalOptima)
  - CalOptima Homeless Response Team (CalOptima)
  - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
  - Opioid prescribing interventions (CalOptima)
  - Medication-assisted treatment (County and CalOptima)
  - Substance use disorder centers (County)
  - Medical detox (CalOptima)
  - Social model detox (County)
  - Naloxone (County and CalOptima)
  - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
  - Moderate-severe behavioral health (County)
    - Crisis intervention
    - Post-acute transitions
    - Intensive outpatient treatment programs
  - Mild-moderate behavioral health (CalOptima)
    - Screening
    - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee
Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

Ad Hoc Recommendations

- Take action to commit $100 million for homeless health
  - Create a restricted homeless health reserve
  - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$1.2 million	$4.8 million	IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)		$10 million	
New Initiatives		$60 million	
Total Reserve: $100 million	**$25.2 million**	**$74.8 million**	

Clinical Field Team Structure

- Team Components
  - Includes clinical and support staff
  - Vehicle for transportation of staff and equipment
  - Internet connectivity and use of Whole-Person Care (WPC) Connect
- Clinical Services
  - Urgent care, wound care, vaccinations, health screening and point-of-care labs
  - Prescriptions and immediate dispensing of commonly used medications
  - Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
  - Coordination with CalOptima Homeless Response Team
  - Coordination with providers
  - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
  - Regular hours at shelters/hot spots
  - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
  - AltaMed
  - Central City Community Health Center*
  - Hurtt Family Health Clinic*
  - Korean Community Services*
  - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
  - Deploy on a phased basis, based on FQHC readiness

** Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
  - Available to Blue Shirts and CHAT-H nurses
  - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
  - Establish working in-person relationships with collaborating partners
  - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
  - Maximum flexibility with access to any provider (no PCP assignment)
  - Fast-tracked authorization processing
  - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
  - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
  - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
  - $2 million financial impact per year
  - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
  - Reallocate $250,000 of the $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
  - Leverage existing process
    - County to coordinate and pay recuperative care vendor
    - CalOptima to reimburse County for 100 percent of cost
  - COBAR in April
  - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
  - Specifically used for homeless individuals
  - Includes social supports and referrals to services
  - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
  - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
  - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
  - Case management staff is trained and actively uses the system
    - Identify members enrolled in WPC
    - Coordinate with other partners caring for members
    - Access information from other partners

- Status of WPC Connect
  - Five hospitals are currently connected
  - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
  - Regulatory and legislative
  - Available permanent supportive housing and shelters
  - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
  - Enrollment assistance
  - Enhanced data connectivity technology
  - Housing supportive services
  - Other physical health services
  - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
  - Clinical field team implementation
  - Medical respite program
  - Homeless coordination at hospitals

- Additional action recommended by Board Ad Hoc
  - Create a restricted homeless health reserve in the amount of $100 million
    - $24 million – previously approved initiatives using IGT 1–7 funds
    - $76 million – all IGT 8 funds (approximately $43 million) with balance from FY 2018–19 operating funds
  - Stipulate that funds can only be used for homeless health

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as "homeless" based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima's ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to $1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

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Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to $1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in $320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- $500,000 from IGT 1 – Depression Screenings;
- $100,000 from IGT 6 – IS and Infrastructure Projects;
- $500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- $500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to $500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to $500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item
S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions
Authorize the $60 million identified for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Background
Supervisor Do is requesting consideration to allocate the $60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:

1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Attachments

1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do

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ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

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choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, $60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the $60 million allocated:

- **C**linic health care services in all homeless shelters - $10 million
- **A**uthorize mobile health team to respond to all homeless providers - $10 million
- **R**esidential support services and housing navigation - $20 million
- **E**xtend recuperative care for homeless individuals with chronic physical health issue-$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CalOptima
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June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of $100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately $100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved $60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - $10 million*
  As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - $10 million*
  Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - $20 million*
  The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - $20 million*
  CalOptima has twice allocated funds for recuperative care, bringing the total to $11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the "urgent" elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,

Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the $60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the $60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of $10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

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the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services "eventually" will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Actions Related to Homeless Health Care Delivery

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer to implement the following operational changes to support homeless health initiatives;
    a. Reallocate $135,000 in Fiscal Year (FY) 2019-20 Medi-Cal budgeted funds under homeless health-related initiatives from medical expenses to administrative expenses;
    b. Implement a pilot program to reimburse Federally Qualified Health Centers (FQHC) and FQHC Look-alikes directly for services provided via mobile health care units or in a fixed shelter location for dates of service from August 1, 2019 through March 31, 2020, based on the CalOptima Medi-Cal fee schedule and for eligible CalOptima Members notwithstanding health network assignment and continuing capitation payments;
    c. With the assistance of Legal Counsel, enter into contract amendments with FQHCs and FQHC Look-alikes providing mobile health care unit services; and
2. Ratify contract amendment with Families Together of Orange County effective May 17, 2019 to participate in the CalOptima Clinical Field Team pilot program providing health care services for homeless members at their locations and provide start-up funding.

Background
CalOptima has launched various initiatives for its Members experiencing homelessness through a series of CalOptima Board of Directors' actions. Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	• Authorized establishment of a Clinical Field Team pilot program • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the Clinical Field Team pilot programs • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to service as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification request for further implementation details • Obtain legal opinion related to using Medi-Cal funding for housing related activities
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members

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	• Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health Actions and contracts with FQHCs • Ratified the implementation plan for the Board authorized Clinical Field Team Pilot Program • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Service the People Community Health Center • Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
June 27, 2019	Authorized $60 million identified for new homeless health initiatives as follows: 1. Clinic health care services in all homeless shelters - $10 million 2. Authorize mobile health team to respond to all homeless providers - $10 million 3. Residential support services and housing navigation - $20 million 4. Extend recuperative care for homeless individuals with chronic physical health issue - $20 million

In addition to the above actions, a Board ad hoc committee focused on homeless health initiatives has engaged numerous community stakeholders, county agencies, providers, health networks, advocates, and other stakeholders to gather information regarding the needs of individuals experiencing homelessness and to make recommendations to the Board on how the health care needs of these members can best be met. The ad hoc's intent is to help develop a thoughtful, strategic approach to leveraging available CalOptima resources to meet the health care needs of homeless members. The overarching goal is to work collaboratively with community partners in developing a health care system that bridges individuals seeking urgently needed health care services where they are located to clinic and office-based settings, while utilizing the existing care management system.

Discussion

Operational changes to support homeless health initiatives

In order to implement the recommended actions, CalOptima staff will make the necessary operational changes and update policy and procedures and return to the Board for approval of any proposed changes to Board-approved policies. Additionally, authority is requested to add two unbudgeted FTE staffing resources, one Sr. Project Manager and one Sr. Program Manager, to support the operational

implementation and ongoing maintenance of homeless health initiatives in CalOptima's Case Management Department. Staff anticipates filling these proposed new positions in September 2019. The total estimated annual cost for the two impact is approximately $324,000, or $270,000 for the ten-month period from September 1, 2019, through June 30, 2020.

Implement pilot program for mobile health units and fixed clinic locations

Based on recent Board actions, CalOptima staff is in the process of expanding healthcare services options available to members experiencing homelessness, including access to preventive and primary services, at the shelter sites. CalOptima staff has also received stakeholder feedback that such services would be of value at other "hot spots," such as parks and soup kitchens. In a separate Board action, CalOptima staff is requesting consideration of modifying its quality improvement strategies, "CalOptima Days", to incentivize FQHCs and FQHC Look-alikes to provide health care services through their mobile units at shelters and other hotspots in the community. Additionally, some clinics are establishing fixed clinical sites within the four walls of the shelter. As proposed, the mobile clinics and fixed shelter locations will establish a regular schedule based on input from the shelters/hotspots, encourage CalOptima Members to seek services from their assigned CalOptima providers, and coordinate services with other medical and behavioral health care providers when appropriate. In order to better monitor utilization and coordination of services on a pilot basis, CalOptima staff recommends reimbursing the clinics for services provided in the mobile unit or fixed shelter location through CalOptima based on the CalOptima Medi-Cal fee schedule regardless of the Member's health network assignment for service rendered August 1, 2019 through March 31, 2020, to coincide with the Clinical Field Team pilot program. Through this process reimbursement will only be provided for Members eligible with CalOptima at the time services are rendered.

Ratify contract amendment with Families Together of Orange County

The Clinical Field Team pilot program is making available urgent care type medical services to Orange County's homeless Members onsite where they are located. This delivery model is designed to reduce delays in care that some homeless Members may experience, whether caused by unwillingness to access services in a typical office-based care setting, challenges with transportation or appointment scheduling, or other factors. Services provided at the Member's location also help prevent or reduce avoidable medical complications such as hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease. For the pilot program, CalOptima has engaged FQHCs (and FQHC Look-alikes) to provide medical services because they provide services to both CalOptima Members and non-CalOptima members; including those who are uninsured. Four community clinics were initially engaged to provide services under the Clinical Field Team pilot program. As indicated, on February 22, 2019, the Board allocated funds for start-up costs for the Clinical Field Team pilot program, resulting in approximately $320,000 in start up funding available per clinic for up to five clinics. Families Together of Orange County was contracted as the fifth provider effective May 17, 2019 and has been provided with start-up funding.

CalOptima staff recommends the Board authorize up to $300,000 from the $10 million allocated on June 27, 2019 towards "Clinic health care services in all homeless shelters" to provide funding for these payments through June 30, 2019. Similar to the Clinical Field Team pilot program, CalOptima will contract with FQHCs and FQHC Look-alikes operating mobile units to provide medical services to CalOptima Members. Reimbursement provided by CalOptima for services provided through the mobile units will apply to CalOptima members as FQHCs are able to obtain alternate funding sources for services provided to individuals not eligible with CalOptima. To be eligible to contract with

CalOptima, the mobile unit must meet Health Resources and Services Administration (HRSA) and CalOptima requirements.

Fiscal Impact

The recommended action to reimburse FQHCs and FQHC look-alikes for services provided in a mobile until for the period August 1, 2019, through March 31, 2020, is a budgeted item. Expenses of up to $300,000 for claims payments and up to $270,000 for staffing expenditures for two new positions is budgeted under homeless health related initiatives in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the "Clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

The recommended action to reallocate $135,000 in budgeted funds within the Medi-Cal line of business from medical expenses to administrative expenses for the Sr. Project Manager position is budget neutral. Staff will monitor the claims volume. To the extent there is an additional fiscal impact, such impact will be addressed in separate Board actions.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for CalOptima Members experiencing homelessness, CalOptima staff recommends these actions to facilitate increased access to services and ongoing operational and clinical support of the initiatives.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Presentation dated March 7, 2019, Homeless Health Update
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. CEO Report to the CalOptima Board of Directors dated May 2, 2019
6. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
APLA Health & Wellness	611 S Kingsley Dr	Los Angeles	CA	90005
Benevolence Industries Inc dba Benevolence Health Centers	1010 Crenshaw Blvd	Torrance	CA	90501
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Central City Community Health Center	1000 San Gabriel Blvd., Suite 200	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 260	La Habra	CA	90631
Hurtt Family Health Clinic, Inc	1 Hope Dr	Tustin	CA	92782
Korean Community Services Inc	8633 Knott Ave	Buena Park	CA	90620
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Development Corpration dba Livingstone Community Health Clinic	12362 Beach Blvd, Suite 10	Stanton	CA	90680
Mission City Community Network Inc	8527 Sepulveda Blvd.	North Hills	CA	91343
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Regional Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868
Serve the People, Inc. dba Serve the People Community Health Center	1206 E 17th St, Suite 101	Santa Ana	CA	92701

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Share our Selves Corporation	1550 Superior Ave	Costa Mesa	CA	92627
Southland Integrated Services Inc dba Southland Health Center	1618 W 1st St	Santa Ana	CA	92703
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
Vista Community Clinic dba VCC The Gary Center	1000 Vale Terrace Dr	Vista	CA	92084

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

Homeless Health Care Delivery

Board of Directors Meeting
March 7, 2019

Michael Schrader
Chief Executive Officer

Agenda

- Clinical field team pilot
- CalOptima Homeless Response Team
- Other expanded service options under consideration

Clinical Field Team Pilot

- Board approved up to $1.6 million in IGT 6/7 dollars for startup funding for a clinical field team (CFT) pilot of up to 1 year with Federally Qualified Health Centers (FQHCs)
- Develop parameters and structure for pilot program
  - Partner with up to five interested FQHCs that will:
    - Establish regular hours at high-volume shelters
    - Deploy to community locations on short notice
    - Coordinate to arrange for coverage with extended hours
    - Deliver urgent-care-type services to homeless individuals in need
      - Bill CalOptima for current CalOptima members
      - FQHCs to seek federal funding as payment for non-CalOptima members
- Staff working to complete contract amendments with FQHCs

Homeless Response Team

- Board authorized CalOptima Homeless Response Team
  - Eight new positions in Case Management department
  - Primary point of contact at CalOptima for homeless health services for CalOptima members
    - Dedicated phone line
    - Extended hours
  - Coordinate scheduling and dispatch of CFTs
  - Work closely with County, shelters and providers
    - Make regular field visits to shelters and recuperative care facilities providing services to CalOptima members
- Recruiting to fill positions

Expanded Service Options Under Consideration

- Embedded clinics at shelters
  - FQHCs to consider establishing regular hours for CFTs at selected high-volume shelters with deployment to other community locations on demand
- Whole-Person Care (WPC) hospital navigators
  - Increase per-diem and APR-DRG reimbursement to contracted hospitals for integrating into the WPC program
- Increased access to skilled nursing services
  - Deliver skilled services (e.g., home health nursing, physical therapy or IV antibiotics, etc.) at recuperative care facilities in lieu of skilled nursing facility placement

Expanded Service Options Under Consideration (cont.)

- Recuperative care beyond 90 days
  - Set up a post-WPC recuperative care program
  - Reallocate part of $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
    - From WPC recuperative care funds
    - To develop post-WPC recuperative care program
- Recuperative care with behavioral health focus
  - Coordinate with County to explore possibilities of:
    - Existing recuperative care facilities dedicating space for CalOptima members with underlying Serious Mental Illness (SMI)
    - Contracting with recuperative care vendor for a dedicated facility with behavioral health focus

Expanded Service Options Under Consideration (cont.)

- Housing supportive services
  - CalOptima could contribute Medi-Cal funding toward housing supportive services (not including rent) for certain CalOptima members under an 1115 waiver program
    - WPC
      - Link clients to other programs that provide housing supportive services
      - Amend County contract with the State to include a funding pool that CalOptima can contribute to for housing supportive services
    - Health Homes Program
      - For members with multiple chronic conditions who also meet acuity criteria (multiple ER visits, inpatient stays or chronic homelessness)
      - Members must elect to participate
      - Care management includes housing navigation

Expanded Service Options Under Consideration (cont.)

- Housing development and rental assistance
  - Obtaining legal opinion
  - Seeking guidance from the Department of Health Care Services

Next Steps

- Conduct further study on expanded service options under consideration, get feedback from stakeholders and return to Board for authority as appropriate on the following possibilities:
  - WPC hospital navigators
  - Increased access to skilled nursing services
  - Recuperative care beyond 90 days
  - Recuperative care with behavioral health focus
  - Housing supportive services
  - Housing development and rental assistance

CalOptima's Mission

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


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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

Michael Schrader
Chief Executive Officer

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as "homeless" based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima's ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to $1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

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Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to $1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in $320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- $500,000 from IGT 1 – Depression Screenings;
- $100,000 from IGT 6 – IS and Infrastructure Projects;
- $500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- $500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to $500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to $500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

MEMORANDUM

DATE:	May 2, 2019
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Homeless Health Initiatives Underway; Clinical Field Teams Launched in April

CalOptima moved our $100 million commitment to homeless health from concept into action this past month in several ways, most notably with the launch of clinical field teams. Guided by your Board's ad hoc committee, which is meeting weekly to spearhead the effort, selected initiatives are summarized below.

- Clinical Field Teams: Launched on time on April 10, CalOptima's first clinical field team conducted its first medical visit with a member at a Santa Ana park. Following a newly established process, the Orange County Health Care Agency's Outreach and Engagement team contacted our internal Homeless Response Team, which then dispatched a Central City Community Health Center (CCCHC) field team, consisting of a physician assistant and medical assistant. The field team treated a member needing care for a sizable open wound. CalOptima and CCCHC agree the initial experience was successful and instructive. Since that time, three other Federally Qualified Health Center (FQHC) partners have begun their programs, including Korean Community Services on April 17, Hurtt Family Health Clinic on April 18 and Serve the People on April 23. We are communicating with other FQHCs, directly and through the Coalition of Orange County Community Health Centers, about their potential participation in the clinical field team program. As we develop a better understanding of the population, its needs and the best methods for serving them, we will continue expanding our coverage.
- Anaheim Encampment: Reflecting our commitment to meeting the healthcare needs of members experiencing homelessness, CalOptima recently participated in a collaborative effort to clear a homeless encampment of approximately 70 people in 40 tents along a stretch of railroad tracks located in Anaheim. The group included the County's Outreach and Engagement team, the City of Anaheim, public health nurses, and other service providers. CalOptima arranged FQHC mobile clinics to work alongside the group to address any medical needs of the homeless. In addition, CalOptima had a case manager on site to make referrals.
- Use of Funds: Approximately $60 million of CalOptima's homeless health commitment is for new initiatives not yet identified. CalOptima is obligated to follow statutory, regulatory, and contractual requirements in determining the type of initiatives that are permissible. To that end, CalOptima has publicly shared the "Use of CalOptima Funds" document that follows this report. The information about the agency's framework and

allowable use of funds will ensure the community is aware of the principles guiding your Board's decision making regarding homeless health.

- Stakeholder Input: The Board ad hoc committee will be seeking additional input to our homeless health initiatives through meetings with stakeholders. CalOptima is in the process of identifying people and/or organizations to engage and will begin setting up those meetings. Recently, the ad hoc committee met with Former Santa Ana City Councilwoman Michele Martinez, Illumination Foundation CEO Paul Leon and Pastor Donald Dermit, from The Rock Church in Anaheim.
- State Programs and Legislation: Efforts to end the homeless crisis are ongoing statewide, and CalOptima is tracking a variety of bills and programs that have potential to positively impact Orange County. One example is the Housing for a Healthy California Program, which is a new source of funds for supportive housing through the Department of Housing and Community Development (DHCD). The program provides supportive housing for Medi-Cal members to reduce financial burdens related to medical and public services overutilization. DHCD is expected to open applications to supportive housing owners and developers for grants that total $36 million statewide. Orange County Health Care Agency intends to work with owners and developers to explore this funding opportunity. Separately, Assembly Bill 563 is state legislation that would grant the North Orange County Public Safety Task Force $16 million in funding to set up comprehensive crisis intervention infrastructure. The aim is to mitigate the local mental health and homeless crisis by expanding and coordinating the many available services, potentially through the Be Well OC Regional Mental Health and Wellness Campus. The bill is currently in the early stages of the legislative process.

Impact of New Knox-Keene Licensure Regulation Will Be Mitigated by Exemptions

With an effective date of July 1, 2019, a new Department of Managed Health Care (DMHC) global risk regulation will substantially expand the number of health care organizations required to have a Knox-Keene license. Fortunately, CalOptima was able to mitigate local concerns that the rule applied to our delegated health networks, which operate under three models — Health Maintenance Organizations (HMOs), Physician-Hospital Consortia (PHCs) and Shared-Risk Groups (SRGs). DHMC has now confirmed that CalOptima's limited Knox-Keene licensed HMO health networks may continue their current contractual arrangements with CalOptima, and the regulator has reached out to our partners to update their licenses. With regard to PHCs and SRGs, the DMHC has reviewed CalOptima's template contracts and believes that these limited risk-sharing arrangements will qualify for exemptions from the new licensure requirement. Contracts that renew or are amended after July 1, 2019, will need to be submitted to the DMHC for a review and exemption process that is anticipated to take no longer than 30 days. CalOptima staff has informed our health network partners about this latest positive development.

California Children's Services (CCS) Advisory Group Meeting Focuses on CalOptima Readiness for Transition

Implementation of the Whole-Child Model (WCM) for CCS in Orange County is now only two months away. Given our impending transition, CalOptima was the focus of an April 10 meeting of the CCS Advisory Group, a highly engaged Department of Health Care Services (DHCS)-appointed panel of medical experts and member advocates who are dedicated to ensuring the WCM effectively serves children with complex CCS conditions. CalOptima Chief Medical Officer David Ramirez, M.D., Executive Director of Clinical Operations Tracy Hitzeman and

Thanh-Tam Nguyen, M.D., our medical director for WCM, shared detailed information about our authorization process, provider panel, delegated delivery system and more, all from the member's perspective. Our WCM Family Advisory Committee Representative Kristen Rogers also spoke. The meeting was an important opportunity to instill confidence about our ability to effectively integrate the CCS program, and we successfully demonstrated CalOptima's careful preparations for WCM. Feedback from the advisory group and DHCS leaders was supportive.

Future Medi-Cal Expansion (MCE) Rates Face Likely Reduction as State Regulator Examines CalOptima Reimbursement

Following a trend established across the past few years, DHCS is signaling a likely reduction in CalOptima's MCE capitation rates for FY 2019–20. Staff was notified in April that a significant adjustment may be ahead, based on the fact that CalOptima's reimbursement for the MCE population is a noticeable outlier. Specifically, DHCS identified that CalOptima's provider capitation and risk pool incentive payouts are significantly higher than those paid by other managed care plans in California. Staff has been in close communication with state officials who will soon share our draft rates. Importantly, we are continuing to communicate with our provider partners so they can plan ahead for a possible reduction. As more information becomes available, staff will look to your Board's Finance and Audit Committee for guidance on any adjustments to provider reimbursement.

CalOptima Welcomes New Executive Director, Human Resources

This past month, Brigette Gibb joined CalOptima as Executive Director, Human Resources. She has more than 35 years of public-sector experience. Most recently, Ms. Gibb worked as the human resources director for the Orange County Fire Authority (OFCA), where she led and directed the administration, coordination and evaluation of all human resources and risk management functions. She has established and maintained effective working relationships with the OCFA Board of Directors, city managers, executive team members and labor group representatives. She holds a master's degree in public administration, with a concentration in human resources, from California State University, Fullerton.

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item
S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions
Authorize the $60 million identified for new homeless health initiatives as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Background
Supervisor Do is requesting consideration to allocate the $60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Attachments
1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

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choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, $60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the $60 million allocated:

- **C**linic health care services in all homeless shelters - $10 million
- **A**uthorize mobile health team to respond to all homeless providers - $10 million
- **R**esidential support services and housing navigation - $20 million
- **E**xtend recuperative care for homeless individuals with chronic physical health issue-$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CalOptima
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June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of $100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately $100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved $60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - $10 million*
  As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - $10 million*
  Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - $20 million*
  The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - $20 million*
  CalOptima has twice allocated funds for recuperative care, bringing the total to $11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the "urgent" elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,

Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the $60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the $60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of $10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

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the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services "eventually" will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Actions Related to Homeless Health Care Delivery

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer to implement the following operational changes to support homeless health initiatives;
    a. Reallocate $135,000 in Fiscal Year (FY) 2019-20 Medi-Cal budgeted funds under homeless health-related initiatives from medical expenses to administrative expenses;
    b. Implement a pilot program to reimburse Federally Qualified Health Centers (FQHC) and FQHC Look-alikes directly for services provided via mobile health care units or in a fixed shelter location for dates of service from August 1, 2019 through March 31, 2020, based on the CalOptima Medi-Cal fee schedule and for eligible CalOptima Members notwithstanding health network assignment and continuing capitation payments;
    c. With the assistance of Legal Counsel, enter into contract amendments with FQHCs and FQHC Look-alikes providing mobile health care unit services; and
2. Ratify contract amendment with Families Together of Orange County effective May 17, 2019 to participate in the CalOptima Clinical Field Team pilot program providing health care services for homeless members at their locations and provide start-up funding.

Background
CalOptima has launched various initiatives for its Members experiencing homelessness through a series of CalOptima Board of Directors' actions. Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	• Authorized establishment of a Clinical Field Team pilot program • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the Clinical Field Team pilot programs • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to service as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification request for further implementation details • Obtain legal opinion related to using Medi-Cal funding for housing related activities
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members

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	• Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health Actions and contracts with FQHCs • Ratified the implementation plan for the Board authorized Clinical Field Team Pilot Program • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Service the People Community Health Center • Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
June 27, 2019	Authorized $60 million identified for new homeless health initiatives as follows: 1. Clinic health care services in all homeless shelters - $10 million 2. Authorize mobile health team to respond to all homeless providers - $10 million 3. Residential support services and housing navigation - $20 million 4. Extend recuperative care for homeless individuals with chronic physical health issue - $20 million

In addition to the above actions, a Board ad hoc committee focused on homeless health initiatives has engaged numerous community stakeholders, county agencies, providers, health networks, advocates, and other stakeholders to gather information regarding the needs of individuals experiencing homelessness and to make recommendations to the Board on how the health care needs of these members can best be met. The ad hoc's intent is to help develop a thoughtful, strategic approach to leveraging available CalOptima resources to meet the health care needs of homeless members. The overarching goal is to work collaboratively with community partners in developing a health care system that bridges individuals seeking urgently needed health care services where they are located to clinic and office-based settings, while utilizing the existing care management system.

Discussion

Operational changes to support homeless health initiatives

In order to implement the recommended actions, CalOptima staff will make the necessary operational changes and update policy and procedures and return to the Board for approval of any proposed changes to Board-approved policies. Additionally, authority is requested to add two unbudgeted FTE staffing resources, one Sr. Project Manager and one Sr. Program Manager, to support the operational

implementation and ongoing maintenance of homeless health initiatives in CalOptima's Case Management Department. Staff anticipates filling these proposed new positions in September 2019. The total estimated annual cost for the two impact is approximately $324,000, or $270,000 for the ten-month period from September 1, 2019, through June 30, 2020.

Implement pilot program for mobile health units and fixed clinic locations

Based on recent Board actions, CalOptima staff is in the process of expanding healthcare services options available to members experiencing homelessness, including access to preventive and primary services, at the shelter sites. CalOptima staff has also received stakeholder feedback that such services would be of value at other "hot spots," such as parks and soup kitchens. In a separate Board action, CalOptima staff is requesting consideration of modifying its quality improvement strategies, "CalOptima Days", to incentivize FQHCs and FQHC Look-alikes to provide health care services through their mobile units at shelters and other hotspots in the community. Additionally, some clinics are establishing fixed clinical sites within the four walls of the shelter. As proposed, the mobile clinics and fixed shelter locations will establish a regular schedule based on input from the shelters/hotspots, encourage CalOptima Members to seek services from their assigned CalOptima providers, and coordinate services with other medical and behavioral health care providers when appropriate. In order to better monitor utilization and coordination of services on a pilot basis, CalOptima staff recommends reimbursing the clinics for services provided in the mobile unit or fixed shelter location through CalOptima based on the CalOptima Medi-Cal fee schedule regardless of the Member's health network assignment for service rendered August 1, 2019 through March 31, 2020, to coincide with the Clinical Field Team pilot program. Through this process reimbursement will only be provided for Members eligible with CalOptima at the time services are rendered.

Ratify contract amendment with Families Together of Orange County

The Clinical Field Team pilot program is making available urgent care type medical services to Orange County's homeless Members onsite where they are located. This delivery model is designed to reduce delays in care that some homeless Members may experience, whether caused by unwillingness to access services in a typical office-based care setting, challenges with transportation or appointment scheduling, or other factors. Services provided at the Member's location also help prevent or reduce avoidable medical complications such as hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease. For the pilot program, CalOptima has engaged FQHCs (and FQHC Look-alikes) to provide medical services because they provide services to both CalOptima Members and non-CalOptima members; including those who are uninsured. Four community clinics were initially engaged to provide services under the Clinical Field Team pilot program. As indicated, on February 22, 2019, the Board allocated funds for start-up costs for the Clinical Field Team pilot program, resulting in approximately $320,000 in start up funding available per clinic for up to five clinics. Families Together of Orange County was contracted as the fifth provider effective May 17, 2019 and has been provided with start-up funding.

CalOptima staff recommends the Board authorize up to $300,000 from the $10 million allocated on June 27, 2019 towards "Clinic health care services in all homeless shelters" to provide funding for these payments through June 30, 2019. Similar to the Clinical Field Team pilot program, CalOptima will contract with FQHCs and FQHC Look-alikes operating mobile units to provide medical services to CalOptima Members. Reimbursement provided by CalOptima for services provided through the mobile units will apply to CalOptima members as FQHCs are able to obtain alternate funding sources for services provided to individuals not eligible with CalOptima. To be eligible to contract with

CalOptima, the mobile unit must meet Health Resources and Services Administration (HRSA) and CalOptima requirements.

Fiscal Impact

The recommended action to reimburse FQHCs and FQHC look-alikes for services provided in a mobile until for the period August 1, 2019, through March 31, 2020, is a budgeted item. Expenses of up to $300,000 for claims payments and up to $270,000 for staffing expenditures for two new positions is budgeted under homeless health related initiatives in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the "Clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

The recommended action to reallocate $135,000 in budgeted funds within the Medi-Cal line of business from medical expenses to administrative expenses for the Sr. Project Manager position is budget neutral. Staff will monitor the claims volume. To the extent there is an additional fiscal impact, such impact will be addressed in separate Board actions.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for CalOptima Members experiencing homelessness, CalOptima staff recommends these actions to facilitate increased access to services and ongoing operational and clinical support of the initiatives.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Presentation dated March 7, 2019, Homeless Health Update
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. CEO Report to the CalOptima Board of Directors dated May 2, 2019
6. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
APLA Health & Wellness	611 S Kingsley Dr	Los Angeles	CA	90005
Benevolence Industries Inc dba Benevolence Health Centers	1010 Crenshaw Blvd	Torrance	CA	90501
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Central City Community Health Center	1000 San Gabriel Blvd., Suite 200	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 260	La Habra	CA	90631
Hurtt Family Health Clinic, Inc	1 Hope Dr	Tustin	CA	92782
Korean Community Services Inc	8633 Knott Ave	Buena Park	CA	90620
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Development Corpration dba Livingstone Community Health Clinic	12362 Beach Blvd, Suite 10	Stanton	CA	90680
Mission City Community Network Inc	8527 Sepulveda Blvd.	North Hills	CA	91343
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Regional Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868
Serve the People, Inc. dba Serve the People Community Health Center	1206 E 17th St, Suite 101	Santa Ana	CA	92701

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Share our Selves Corporation	1550 Superior Ave	Costa Mesa	CA	92627
Southland Integrated Services Inc dba Southland Health Center	1618 W 1st St	Santa Ana	CA	92703
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
Vista Community Clinic dba VCC The Gary Center	1000 Vale Terrace Dr	Vista	CA	92084

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

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Homeless Health Care Delivery

Board of Directors Meeting
March 7, 2019

Michael Schrader
Chief Executive Officer

CalOptima
A Public Agency
Better. Together.

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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

Michael Schrader
Chief Executive Officer

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246 8400

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as "homeless" based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima's ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to $1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

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Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to $1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in $320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- $500,000 from IGT 1 – Depression Screenings;
- $100,000 from IGT 6 – IS and Infrastructure Projects;
- $500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- $500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to $500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to $500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701

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Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

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MEMORANDUM

DATE:	May 2, 2019
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Homeless Health Initiatives Underway; Clinical Field Teams Launched in April
CalOptima moved our $100 million commitment to homeless health from concept into action this past month in several ways, most notably with the launch of clinical field teams. Guided by your Board's ad hoc committee, which is meeting weekly to spearhead the effort, selected initiatives are summarized below.

- Clinical Field Teams: Launched on time on April 10, CalOptima's first clinical field team conducted its first medical visit with a member at a Santa Ana park. Following a newly established process, the Orange County Health Care Agency's Outreach and Engagement team contacted our internal Homeless Response Team, which then dispatched a Central City Community Health Center (CCCHC) field team, consisting of a physician assistant and medical assistant. The field team treated a member needing care for a sizable open wound. CalOptima and CCCHC agree the initial experience was successful and instructive. Since that time, three other Federally Qualified Health Center (FQHC) partners have begun their programs, including Korean Community Services on April 17, Hurtt Family Health Clinic on April 18 and Serve the People on April 23. We are communicating with other FQHCs, directly and through the Coalition of Orange County Community Health Centers, about their potential participation in the clinical field team program. As we develop a better understanding of the population, its needs and the best methods for serving them, we will continue expanding our coverage.
- Anaheim Encampment: Reflecting our commitment to meeting the healthcare needs of members experiencing homelessness, CalOptima recently participated in a collaborative effort to clear a homeless encampment of approximately 70 people in 40 tents along a stretch of railroad tracks located in Anaheim. The group included the County's Outreach and Engagement team, the City of Anaheim, public health nurses, and other service providers. CalOptima arranged FQHC mobile clinics to work alongside the group to address any medical needs of the homeless. In addition, CalOptima had a case manager on site to make referrals.
- Use of Funds: Approximately $60 million of CalOptima's homeless health commitment is for new initiatives not yet identified. CalOptima is obligated to follow statutory, regulatory, and contractual requirements in determining the type of initiatives that are permissible. To that end, CalOptima has publicly shared the "Use of CalOptima Funds" document that follows this report. The information about the agency's framework and

allowable use of funds will ensure the community is aware of the principles guiding your Board's decision making regarding homeless health.

- Stakeholder Input: The Board ad hoc committee will be seeking additional input to our homeless health initiatives through meetings with stakeholders. CalOptima is in the process of identifying people and/or organizations to engage and will begin setting up those meetings. Recently, the ad hoc committee met with Former Santa Ana City Councilwoman Michele Martinez, Illumination Foundation CEO Paul Leon and Pastor Donald Dermit, from The Rock Church in Anaheim.
- State Programs and Legislation: Efforts to end the homeless crisis are ongoing statewide, and CalOptima is tracking a variety of bills and programs that have potential to positively impact Orange County. One example is the Housing for a Healthy California Program, which is a new source of funds for supportive housing through the Department of Housing and Community Development (DHCD). The program provides supportive housing for Medi-Cal members to reduce financial burdens related to medical and public services overutilization. DHCD is expected to open applications to supportive housing owners and developers for grants that total $36 million statewide. Orange County Health Care Agency intends to work with owners and developers to explore this funding opportunity. Separately, Assembly Bill 563 is state legislation that would grant the North Orange County Public Safety Task Force $16 million in funding to set up comprehensive crisis intervention infrastructure. The aim is to mitigate the local mental health and homeless crisis by expanding and coordinating the many available services, potentially through the Be Well OC Regional Mental Health and Wellness Campus. The bill is currently in the early stages of the legislative process.

Impact of New Knox-Keene Licensure Regulation Will Be Mitigated by Exemptions

With an effective date of July 1, 2019, a new Department of Managed Health Care (DMHC) global risk regulation will substantially expand the number of health care organizations required to have a Knox-Keene license. Fortunately, CalOptima was able to mitigate local concerns that the rule applied to our delegated health networks, which operate under three models — Health Maintenance Organizations (HMOs), Physician-Hospital Consortia (PHCs) and Shared-Risk Groups (SRGs). DHMC has now confirmed that CalOptima's limited Knox-Keene licensed HMO health networks may continue their current contractual arrangements with CalOptima, and the regulator has reached out to our partners to update their licenses. With regard to PHCs and SRGs, the DMHC has reviewed CalOptima's template contracts and believes that these limited risk-sharing arrangements will qualify for exemptions from the new licensure requirement. Contracts that renew or are amended after July 1, 2019, will need to be submitted to the DMHC for a review and exemption process that is anticipated to take no longer than 30 days. CalOptima staff has informed our health network partners about this latest positive development.

California Children's Services (CCS) Advisory Group Meeting Focuses on CalOptima Readiness for Transition

Implementation of the Whole-Child Model (WCM) for CCS in Orange County is now only two months away. Given our impending transition, CalOptima was the focus of an April 10 meeting of the CCS Advisory Group, a highly engaged Department of Health Care Services (DHCS)-appointed panel of medical experts and member advocates who are dedicated to ensuring the WCM effectively serves children with complex CCS conditions. CalOptima Chief Medical Officer David Ramirez, M.D., Executive Director of Clinical Operations Tracy Hitzeman and

Thanh-Tam Nguyen, M.D., our medical director for WCM, shared detailed information about our authorization process, provider panel, delegated delivery system and more, all from the member's perspective. Our WCM Family Advisory Committee Representative Kristen Rogers also spoke. The meeting was an important opportunity to instill confidence about our ability to effectively integrate the CCS program, and we successfully demonstrated CalOptima's careful preparations for WCM. Feedback from the advisory group and DHCS leaders was supportive.

Future Medi-Cal Expansion (MCE) Rates Face Likely Reduction as State Regulator Examines CalOptima Reimbursement

Following a trend established across the past few years, DHCS is signaling a likely reduction in CalOptima's MCE capitation rates for FY 2019–20. Staff was notified in April that a significant adjustment may be ahead, based on the fact that CalOptima's reimbursement for the MCE population is a noticeable outlier. Specifically, DHCS identified that CalOptima's provider capitation and risk pool incentive payouts are significantly higher than those paid by other managed care plans in California. Staff has been in close communication with state officials who will soon share our draft rates. Importantly, we are continuing to communicate with our provider partners so they can plan ahead for a possible reduction. As more information becomes available, staff will look to your Board's Finance and Audit Committee for guidance on any adjustments to provider reimbursement.

CalOptima Welcomes New Executive Director, Human Resources

This past month, Brigette Gibb joined CalOptima as Executive Director, Human Resources. She has more than 35 years of public-sector experience. Most recently, Ms. Gibb worked as the human resources director for the Orange County Fire Authority (OFCA), where she led and directed the administration, coordination and evaluation of all human resources and risk management functions. She has established and maintained effective working relationships with the OCFA Board of Directors, city managers, executive team members and labor group representatives. She holds a master's degree in public administration, with a concentration in human resources, from California State University, Fullerton.

SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item
S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions
Authorize the $60 million identified for new homeless health initiatives as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Background
Supervisor Do is requesting consideration to allocate the $60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Attachments
1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

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choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, $60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the $60 million allocated:

- **C**linic health care services in all homeless shelters - $10 million
- **A**uthorize mobile health team to respond to all homeless providers - $10 million
- **R**esidential support services and housing navigation - $20 million
- **E**xtend recuperative care for homeless individuals with chronic physical health issue-$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CalOptima
A Public Agency
Better. Together.

June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of $100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately $100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved $60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - $10 million*
  As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - $10 million*
  Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - $20 million*
  The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - $20 million*
  CalOptima has twice allocated funds for recuperative care, bringing the total to $11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the "urgent" elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,

Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the $60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the $60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of $10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

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the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services "eventually" will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative.

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality & Population Health Management, (714) 246-8400

Recommended Actions

1. Authorize modification of the existing "CalOptima Day" Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
2. Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
3. Authorize the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program.

Background

"CalOptima Day" is one of the Quality Improvement and incentive strategies approved by the Board on December 1, 2016 as part Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to $1.1Millon. CalOptima Day aims to increase access to care, enhance the member experience, and improve quality outcomes in collaboration with health networks and CalOptima Community Network provider offices. CalOptima Days are half- or full-day health and wellness events for high-volume provider offices or clinics chosen by health networks. Staff works with the provider office/clinic to schedule members to receive necessary preventive services on CalOptima Day. The provider office/clinic earns incentives for each completed preventive health visit, as evidenced by billing/encounter reporting using codes in accordance to the Healthcare Effectiveness Data and Information Set (HEDIS) specifications. The intent of these initiatives is to increase access to care and provide CalOptima members with immunizations, well-care visits and/or other services tied to quality measures. CalOptima Days have proven to be an impactful quality activity since they began in 2016. Due to the many benefits linked to CalOptima Days, they are now part of an ongoing quality strategy to improve access to preventive care and performance on quality measures.

During the February, April and June 2019 CalOptima Board meetings, the Board approved various homeless health initiatives, including an implementation plan for the Clinical Field Team Pilot Program (CFTPP) and contracts with Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes (jointly Community Health Centers) selected to participate in the CFTPP.

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As part of the CFTPP, CalOptima amended its contracts with five Community Health Centers to provide on-call services at hot spots throughout the county such as parks, encampments and shelters to address urgent clinical needs of individuals experiencing homelessness.

Further, the Board requested that CalOptima staff focus on significantly expanding preventive and primary care services at homeless shelter sites. CalOptima also received stakeholder feedback that such services would also be valuable at other hot spots, such as soup kitchens. CalOptima staff proposes expansion of the CalOptima Day model to provide greater access to preventive and primary care services at these locations in collaboration with interested Community Health Centers, whether they participate in CFTPP or not.

At its June 27, 2019 special meeting, the Board approved funding allocations for $60 million in new Homeless Health Initiatives. As part of this action, the Board allocated $10 million to "Clinic health care services in all homeless shelters."

Discussion

Staff recognizes the need for members experiencing homelessness to have reliable access to preventive and primary care in shelters and at other settings. Many shelters already have established relationships with community providers to provide those services via either an on-site or mobile clinic; however, hours may be limited. These services are sometimes not be billed, even when a provider is rendering services to a CalOptima member. This may occur, for example, if the provider is not contracted with the member's assigned health network or is not the member's assigned primary care provider (PCP). Further, some Community Health Centers have advised that set up and tear down of mobile clinics is time consuming and may not be cost-effective, even if the clinic is able to bill for the visit. These factors may contribute to limited access to care at shelters and other hot spots.

To address these concerns, CalOptima staff proposes partnering with any interested Community Health Centers to provide preventive and primary health care services at shelters and other hot spots. This may include locations that do not have established schedules with community providers, as well as those that may benefit from expanded schedules. These Community Health Centers will be required to create a regular schedule based on input from the shelters/hot spots, and those schedules will be informed by need, which may include bed count, frequency of resident turnover, other individuals served at the location, existing service schedules, and proximity to community providers. Additionally, the Community Health Centers will be expected to encourage CalOptima members to seek services from their assigned CalOptima providers and coordinate services with other medical and behavioral health care providers.

As proposed, and similar to the CalOptima Day tiered incentive payment model, clinics maintaining a presence at the shelter or hot spot will be compensated up to $1 million annually in total for all participating providers, excluding CalOptima staff resources, based on expanded hours and services completed for CalOptima members, as well as claims submission.

CalOptima staff proposes to offer eligible providers with a monetary incentive for participating in the HCAP according to two (2) tiers:

- Tier 1: An eligible provider will receive a Tier 1 provider incentive for event participation for a half day (4 hours) or a full day (8 hours).

- Tier 2: An eligible provider may receive a Tier 2 provider incentive, in addition to the Tier 1 provider incentive, if the following levels of services are provided:
    - Eligible provider completes 10 appointments during a half day (4 hours). Appointments may be any combination of well-care or vaccine-only visit.
    - Eligible provider completes 20 appointments during a full day (8 hours). Appointments may be any combination of well-care or vaccine-only visit.

Provider Incentive	Half Day (4 hours)	Full Day (8 hours)
Tier 1	$800	$1,600
Tier 2	$400	$800

Staff estimates that CalOptima will schedule a combination of 10 half day or full day HCAP events per week, with an average of 15 appointments completed during each event.

CalOptima staff will leverage the coordination and incentive mechanisms already established by the current CalOptima Day strategy. The effectiveness of CalOptima Days is measured by lead measures such as numbers of members accessing services, numbers of CalOptima Days with expanded hours, and lag measures such as HEDIS. A similar program measurement and evaluation discipline will apply to the HCAP.

In addition, management requests additional staffing to coordinate HCAP. Staff recommends the addition of two full-time equivalent positions: a Program Manager and a Quality Analyst. The total estimated annual impact of the addition of the two staff positions is approximately $231,087.

Fiscal Impact

The recommended action to develop HCAP by modifying the existing CalOptima Day Quality Improvement and incentive strategy is a Homeless Health Initiative budgeted item. Expenses of up to $1 million annually for provider incentives and $231,087 annually for staffing expenditures are budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget approved by the Board on June 6, 2019 and will be funded from the "clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

Rationale for Recommendation

CalOptima members experiencing homelessness sometimes face unique challenges in accessing the care they need. By partnering with shelters, other hot spots and Community Health Centers to implement the HCAP will help provide members with access to preventive and primary health services that this population segment may not otherwise seek. Early intervention while the members reside in shelters could also help them reacclimate to receiving scheduled care by appointment, hopefully helping to reintroduce them to obtaining health care in a more traditional and cost-effective setting.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Homeless Clinic Access Program Presentation
2. Board approval of Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to $1.1Millon. on December 1, 2016
3. CalOptima Day Fact Sheet

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

CalOptima Homeless Clinic Access Program

David Ramirez, M.D.
Chief Medical Officer

Betsy Ha, R.N., M.S., LSSMBB
Executive Director, Quality & Population Health Management

Building a Better System of Care

- In response to the homelessness crisis in Orange County, CalOptima has approved the following:
  - Homeless Response Team to coordinate care
  - Deployed the Clinical Field Team in collaboration with Federally Qualified Health Centers (FQHC) to provide urgent care for those unable or unwilling to access the traditional care system
  - Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination
  - Increased Recuperative Care funding and creation of a Medical Respite Program
- These initiatives focus on the urgent and clinical needs of members unsheltered.

Bridging to Existing System

Nontraditional Settings

- Clinical Field Teams (CFTs)
- Mobile Clinics
- Telehealth

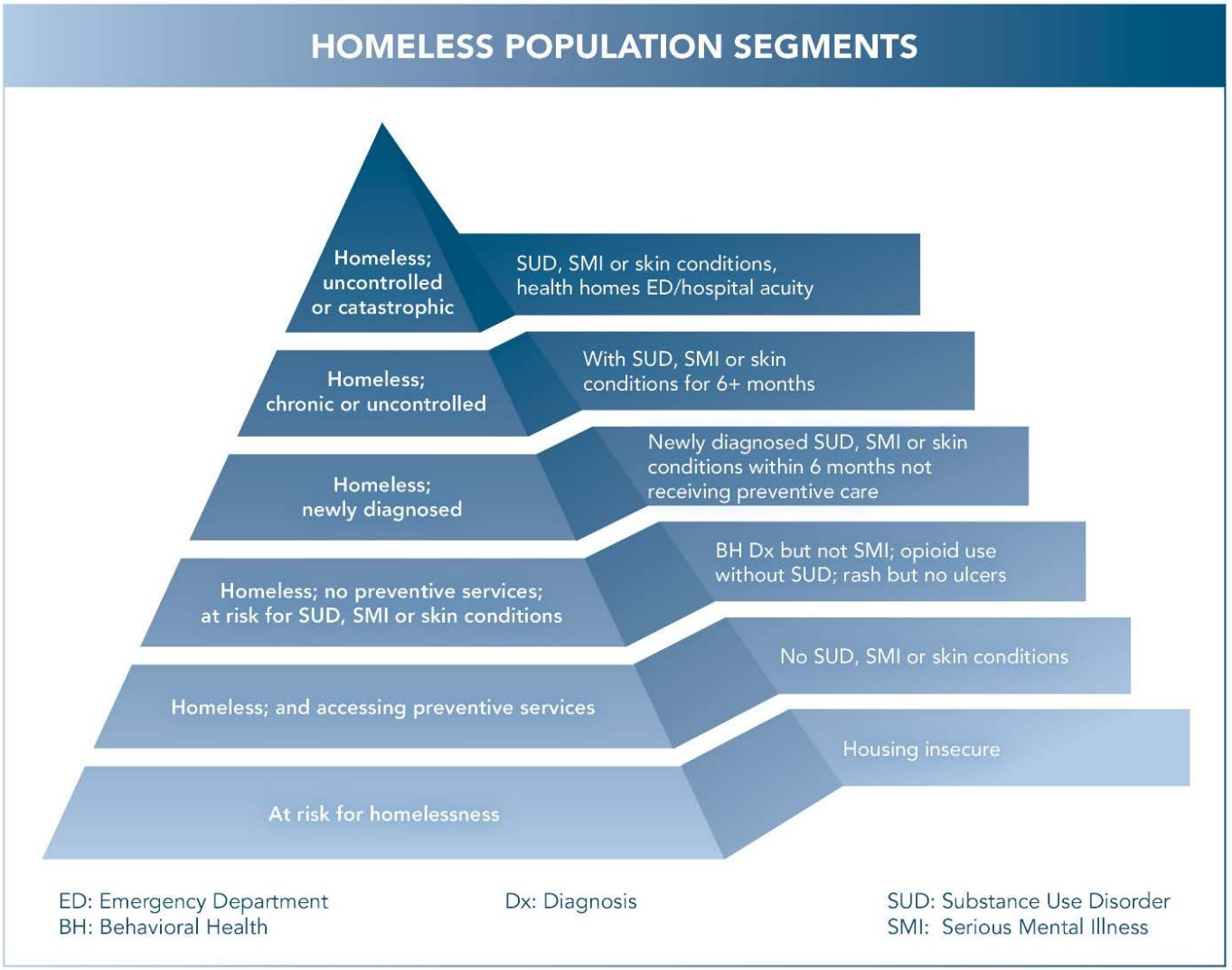
Transitional Settings

- Clinics in Shelters
- On-Site Supportive Services

Existing System

- Clinics
- Office-Based Providers
- Telephonic Case Management

A Population Health Approach



Clinic Health Care Services

- In response to the June 27, 2019, special meeting, the Board approved funding allocations of $60 million for new homeless health initiatives.
- As part of this action, the Board allocated $10 million to “Clinic health care services in all homeless shelters.”
- Staff recognizes the need to establish reliable, recurring, preventive and primary care schedules for members experiencing homelessness who are staying in shelters.
- Currently, most shelters in Orange County have inadequate physical health services available either on-site or through mobile clinics

Leveraging Quality Incentives

Modify the “CalOptima Day” Quality Improvement and incentive strategy for Homeless Health Initiative

Develop a CalOptima Homeless Clinic Access Program (HCAP)

Provide CalOptima Homeless Clinic Access Program (HCAP) at Orange County homeless shelters and other appropriate locations

What is CalOptima Day?

- A practice site-based Quality Improvement and incentive strategy used by CalOptima since 2016 to improve member access to care and HEDIS performance results
  - A half or full-day health and wellness event that is co-hosted by CalOptima, a health network, and a clinic or provider office, offering immunizations and well-care visits to our Medi-Cal members.
  - Clinic/providers offices' to only schedule appointments for CalOptima members assigned to the participating health network and clinic/provider office designated CalOptima Days.
  - Providers are incentivized to host the event and can receive up to $2,400 per CalOptima Day.
  - Members are incentivized with a $25 gift card for completing a visit.

2018 CalOptima Day Focused Measures

- Well-Care Measures
  - Well-Child Visits in the First 15 Months of Life (W15)
  - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
  - Adolescent Well-Care Visits (AWC)
- Immunization Measures
  - Childhood Immunization Status (CIS)
    - Combo 10
  - Immunizations for Adolescents (AWC)
    - Combo 2

CalOptima Homeless Clinic Access Program (HCAP)

- Increase the availability of preventive and routine health care services at Orange County shelters to create regular clinic schedules informed by need.
- Provide care transition support and encourage CalOptima members to seek services from their assigned CalOptima providers.
- Coordinate services with other medical and behavioral health care providers when needed.

Proposed Quality Measures

- Preventive services, screenings and chronic care HEDIS measures may include but not be limited to:
  - Access to Ambulatory and Preventive Care Services (AAP)
  - Adult BMI Assessment (ABA)
  - Chlamydia Screening (CHL)
  - Cervical Cancer Screening (CCS)
  - Adult Immunization Status (AIS)
  - Comprehensive Diabetes Care (CDC)
    - HbA1C
    - Retinal Eye Exam
    - Blood Pressure

Proposed Provider Incentives

- CalOptima will offer eligible providers a monetary incentive for participating in the CalOptima Homeless Clinic Access Program (HCAP) events according to two (2) tiers:
  - Tier 1: Eligible provider receives a Tier 1 incentive for event participation for a half (4 hours) or full day (8 hours)
  - Tier 2: Eligible provider may receive a Tier 2 provider incentive, in addition to Tier 1, if the following levels or service are provided;
    - Eligible provider completes 10 appointments during half day (4 hours)
    - Eligible provider completes 20 appointments during a full day (8 hours)

Provider Incentive	Half Day (4 Hours)	Full Day (8 Hours)
Tier 1 Incentive	$800	$1,600
Tier 2 Incentive	$400	$800

Fiscal Impact

- Expenses of up to $1 million annually for provider incentives and $231,087 annually for staffing expenditures
- Budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget
- Approved by the Board on June 6, 2019
- Will fund from the “Clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019

Staffing Expenditure

- Hire Program Manager and Quality Analyst
- Perform incentive program management
- Facilitate scheduling
- Provide care transition support
- Monitor quality and access to primary care
- Coordination with internal and external partners
- Quality performance measurement, analysis and reporting

Recommended Action

- Authorize modification of the existing “CalOptima Day” Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
- Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
- Authorize the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program.

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Approve the Quality Improvement activities listed on Attachment 1;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process;
3. Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1., subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and
4. Authorize unbudgeted expenditures not to exceed $1.1 million to implement these initiatives.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

One of the areas of focus within Quality Programs and Services is CalOptima's performance in the National Committee for Quality Assurance (NCQA) accreditation and ratings. The evaluation criterion for the NCQA health plan ratings consists of three dimensions: Prevention, Treatment and Member Satisfaction. According to the most recent NCQA Health Plan Ratings, (NCQA's Medicaid Health Insurance Plan Ratings 2015-2016) CalOptima scored 4 out of 5 on Prevention, 3.5 out of 5 on Treatment, and 2.5 out of 5 in Customer Service. Health Plans are rated on a 5 point scale. CalOptima achieved an overall rating of 4 out of 5. CalOptima has the distinction of being the top rated Medicaid Health plan in California for the past three years. CalOptima is proud to be the only California Medicaid health plan accredited at the "commendable" level by NCQA. Additionally, CalOptima has achieved a 3.5 out of 5.0 "STAR" rating for Medicare by the Centers for Medicare & Medicaid Services (CMS).

Although CalOptima has achieved much success in our quality programs, we have also identified two measures that were below the minimum performance level (MPL) established by the California

Department of Health Care Services (DHCS), and we have prospectively identified other quality measures on the decline that are required for NCQA accreditation and health plan ratings. In order to maintain or exceed our quality performance levels, it is imperative to consider additional interventions which are necessary to achieve these goals, as referenced in our 2016 QI Program Description (Clinical Data Warehouse section, pg 41). These include utilizing multiple levers (direct-to-member, direct-to-provider, incentives, communication strategies, etc.) and programs planned as ongoing strategies throughout the calendar year.

In preparing the CalOptima FY 2016-17 Operating Budget, staff applied the regular budgeting methodology which used the past year's actual run-rate assumptions to allocate funds to various categories, units and lines of business. Upon further review, it became clear that additional funding was necessary to meet existing program commitments for Medi-Cal quality monitoring, reporting and improvement as well as new and expanded quality programs.

Discussion

Maintaining CalOptima's "commendable" accreditation status and rating by NCQA as a top Medicaid plan in California requires ongoing investment in innovative quality initiatives focused on underperforming measures as well as measures aligned with NCQA accreditation, health plan ratings, as well as DHCS and CMS requirements. Funding is also requested to maintain current vendor contracts utilized for quality reporting and to support annually required trainings for quality staff.

Expenditures requested are classified as:

• Budget augmentation for current quality initiatives:	$ 457,740
• New requests for quality initiatives:	$ 605,839
Total Request	$1,063,579

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities provides additional detail on the quality related programs, initiatives and proposed incentives. Member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be fully developed and returned for Board approval prior to implementation, as well as regulatory approval, as applicable.

Fiscal Impact

The recommended action to appropriate and authorize expenditures of up to $1.1 million for Medi-Cal quality improvement and accreditation activities is an unbudgeted item. Management is requesting Board approval to authorize an additional amount of up to $1.1 million in medical expenses to fund the cost of the quality improvement activities.

Rationale for Recommendation

CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

Concurrence

Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer
Board of Directors' Quality Assurance Committee
Board of Directors' Finance and Audit Committee

Attachments

- Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
- PowerPoint Presentation: Quality Analytics Budget

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

11/22/2016 — **Date**

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

A. Budget Augmentation for Current Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Surveys & NCQA Fees	• Addition of CG CAHPs - Adult & Child • Fee increases for regular CAHPS • Implement SPD CAHPS • Additional record retrieval for Medical Record Review • Increase in NCQA required fees • Timely Access Survey	$252,937
NCQA Consultant	• RFP results did not produce viable option; completed bid exception for known entity due to timeframe	$17,375
Quality Initiatives in Flight	• Flu/pneumococcal shot reminders • Preventive care visits • Pharyngitis kits • Readmissions project (CMS QIP) • Member & provider communications (more non-adherent members; more measures to move) •	$138,793
	• Member and provider incentives	$12,380
Required Training	• Annual Inovalon & HEDIS Best Practices training • CME expenses for physician training • Provider education activities • New hire equipment	$28,480
Miscellaneous		$7,775
Total		**$457,740**

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

B. New Request for Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Member Programs	• Prenatal/postpartum incentive (Increase volume of outreach; $10,887 • Breast cancer screening -Downward trend Reminder mailing & incentive; $99,900 • Cervical cancer screening -Below MPL Reminder mailing & incentive; $149,900	$260,687
Provider Programs	• Physician office extended hours pilot project - MPL measures ($10,000) • Prenatal/postpartum provider office incentive ($5,000) • PCP office staff incentives for well women visits/screenings ($75,000) • Physician office extended hours initiative mailing ($2,500)	$92,500
Member Experience Initiatives	• Member focus groups, supplemental survey, provider CME ($72,525) • Practice coaches for member experience ($18,840)	$91,365
Provider Toolkits	• AWARE toolkit on antibiotic use ($5,000) • Provider Outreach/Education on AAB Measure (Below MPL; $1,500)	$6,500
Outreach Projects	• PSA for well women visits (Feb & May) - Culturally-specific radio stations ($99,900) • Child & Adolescent Outreach and Events for Childhood Immunizations (13% decrease; $44,887) • Educational posters/print ads for physician offices for Women's Wellness Campaign ($10,000)	$154,787
Total		**$605,839**

Quality Analytics Budget

Board of Directors' Quality Assurance Committee Meeting
November 16, 2016

Board of Directors' Finance and Audit Committee Meeting
November 17, 2016

Richard Bock, MD, Deputy CMO
Caryn Ireland, Executive Director, Quality

FY 2016-2017 Budget

- Budget augmentation for current quality initiatives: $457,740
  - Surveys & NCQA Fees
  - NCQA Consultant
  - Quality Initiatives in Flight
  - Required Training
  - Miscellaneous

- New requests for quality initiatives: $605,839
  - Member Programs
  - Provider Programs
  - Member Experience Initiatives
  - Provider Toolkits
  - Outreach Projects

Budget Augmentation for Current Quality Initiatives: $457,740

- Surveys & NCQA Fees: $252,937
  - Addition of CG CAHPS – Adult & Child
  - Fee increases for regular CAHPS
  - Implement SPD CAHPS
  - Additional record retrieval for Medical Record Review
  - Increase in NCQA required fees
  - Timely Access Survey
- NCQA Consultant: $17,375
  - RFP results did not produce viable option; completed bid exception for known entity due to timeframe
- Quality Initiatives in Flight: $151,173
  - Flu/pneumococcal shot reminders
  - Preventive care visits
  - Pharyngitis kits
  - Readmissions project (CMS QIP)
  - Member communications (more non-adherent members; more measures to move)
  - Member and provider incentives

Budget Augmentation for Current Quality Initiatives (cont.)

- Required Training $28,480
  - Annual Inovalon & HEDIS Best Practices training
  - CME expenses for physician training
  - Provider education activities
  - New hire equipment

- Miscellaneous $7,775

Funding for Additional Program: $605,839

- **Member Programs** — $260,687
  - Prenatal/postpartum incentive (Increase volume of outreach)
  - Breast Cancer Screening (Downward trend)
  - Cervical Cancer Screening (Below MPL)
- **Provider Programs** — $92,500
  - Physician office extended hours pilot project – MPL measures
  - Prenatal/postpartum provider office incentive
  - PCP office staff incentives for well women visits/screenings
  - Physician office extended hours initiative mailing
- **Member Experience Initiatives** — $91,365
  - Member focus groups, supplemental survey, provider CME
  - Practice coaches for member experience
- **Provider Toolkits** — $6,500
  - AWARE toolkit on antibiotic use
  - Provider outreach/education on AAB Measure (Below MPL)
- **Outreach Projects:** — $154,787
  - PSA for well women visits (Feb & May) – Culturally-specific radio stations
  - Child & adolescent outreach and events for childhood immunizations (13% decrease)
  - Educational posters/print ads for physician offices for Women's Wellness Campaign

Description of Additional Programs	Amount
Member Programs	$260,687
Prenatal/postpartum incentive (Increase volume of outreach)	$10,887
Breast cancer screening (Downward trend)	$99,900
Cervical cancer screening (Below MPL) - Reminder mailing and member incentives	$149,900
Provider Programs	$92,500
Physician office extended hours pilot project – MPL measures	$10,000
Prenatal/postpartum provider office incentive	$5,000
PCP office staff incentives for well women visits/screenings	$75,000
Physician office extended hours initiative mailing	$2,500
Member Experience	$91,365
Member focus groups ($50K), supplemental survey ($20,475), provider CME ($7K)	$72,525
Practice coaches for member experience	$18,840
Provider Tool Kits	$6,500
AWARE Toolkit on antibiotic use	$5,000
Provider outreach/education on AAB Measure (Below MPL)	$1,500
Outreach Projects	$154,787
PSA for well women visits (Feb & May) – Culturally-specific radio stations	$99,900
Child & adolescent outreach and events for childhood immunizations (13% decrease)	$44,887
Educational posters/print ads for physician offices for Women's Wellness Campaign	$10,000
Total	**$605,839**

CalOptima's Mission

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


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QUALITY INITIATIVES

"CalOptima Day"
Child and Adolescent Health and Wellness Event

CalOptima strives to provide quality care for our members. This means finding new ways to better serve them. CalOptima is looking for health networks to host CalOptima Day, a one-day health and wellness event at one high-volume provider office or clinic of their choice, offering immunizations and well-care visits to children and adolescent Medi-Cal members.

Criteria for Participation:

- Health networks and the selected provider office or clinic will help market the event as "CalOptima Day."
- Voluntary participation of one provider office or clinic per health network that serves a high volume of targeted CalOptima Medi-Cal members in Orange County
- Provider office or clinic must be in good standing with CalOptima and have no sanctions or corrective action plans in place at the time of participation.
- Health networks and provider office/ clinic are expected to host a wellness event targeting any or all the measures listed: W15, W34, AWC, CIS and IMA.
- Provider offices and clinics are expected to conduct member outreach efforts including outbound calling, scheduling appointments and record keeping.
- Provider offices/ clinics and the health network are expected to properly code the office visit in accordance to the HEDIS specifications and provide validation to CalOptima this occurred.
- The participating provider or clinic shall provide feedback and a summary report of all vaccinations and well-child visits completed at the event.
- CalOptima will provide gift cards to members as incentives for receiving a recommended immunization(s) during the CalOptima Day event.
- CalOptima will offer participating provider offices or clinics a monetary incentive for hosting the health and wellness event of $300/hr. for each health event, up to $2,400/event. Depending on budget, a primary care provider (PCP)/clinic site may conduct more than one event at the discretion of CalOptima.

For more information, email questions to QI_Initiatives@CalOptima.org.

Please note: A limited number of provider offices and/or clinics will be eligible to participate in the Child and Adolescent Health and Wellness Event. Be on the lookout for more opportunities to participate in a CalOptima incentive program.

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Approval of Homeless Health Initiatives Guiding Principles

Contact
Michael Schrader, Chief Executive Officer (714) 246-8400

Recommended Action
Approve Homeless Health Initiatives Guiding Principles and Crosswalk as a framework for future funding allocations.

Background
On April 4, 2019, the CalOptima Board of Directors committed expenditures of $100 million for Homeless Health Initiatives within a three-year period. At that time, $40 million was directed to a range of specific initiatives, including enhanced Medi-Cal services at the Be Well OC Regional Mental Health and Wellness Campus; recuperative care; clinical field team startup costs; CalOptima Homeless Response Team; and homeless coordination at hospitals. An additional $60 million was appropriated for future initiatives. At the special Board meeting on June 27, 2019, a proposal with funding allocations for the $60 million was approved. The funding allocations covered four areas: clinic health care services in all homeless shelters; authorize mobile health team to respond to all homeless providers; residential support services and housing navigation; and extend recuperative care for homeless individuals with chronic physical health issues. On September 5, 2019, staff received Board direction to develop Guiding Principles related to the $60 million allocation and to solicit input from Board members and providers on those principles.

The draft Homeless Health Initiatives Guiding Principles were shared with the Board on September 20, 2019, and a crosswalk of the Guiding Principles and funding categories was later integrated. Both documents were developed in coordination with the Board's ad hoc committee on homeless health. The draft Guiding Principles were also shared with the Orange County Medical Association, the Hospital Association of Southern California and CalOptima health networks. At the October 3, 2019, Board meeting, staff again received direction to bring the Guiding Principles to the full Board for consideration. On October 28, 2019, the California Department of Health Care Services released California Advancing and Innovating Medi-Cal (CalAIM), a proposal with the potential to significantly impact the future Medi-Cal delivery system framework, starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. On November 7, 2019, the Board requested that staff consider the impact of CalAIM on the Guiding Principles, update the document if needed and present the information to the full Board.

Discussion
The Board recognizes that the approved $60 million allocation for the Homeless Health Initiatives allows room for flexibility to execute the new initiatives that are most impactful and relevant to our

members experiencing homelessness. The staff developed the Homeless Health Initiatives Guiding Principles to refine the decision-making process, ensure investment in the most appropriate programs and to address provider concerns. Proposals consistent with the principles will be brought forward for consideration by the Board; proposals that are inconsistent will face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion on the allocation of funds. However, internal and external stakeholders will be able to use the Guiding Principles to support initiatives that unify the community around the shared goal of better serving Orange County's homeless population.

Fiscal Impact

The recommended action is budget neutral. The $60 million allocation has already been approved by the Board. The recommended action has the effect of distributing funds to various as yet undetermined initiatives, but the amount will not exceed $60 million.

Rationale for Recommendation

The above recommendation serves to guide funding allocations for CalOptima's Homeless Health Initiatives to ensure expenditures meet strategic priorities and have the most positive impact for members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Homeless Health Initiatives: Guiding Principles presentation
2. Homeless Health Initiatives Guiding Principles
3. Crosswalk: Guiding Principles and Homeless Health Funding Categories
4. CalAIM Appendix D

/s/ Michael Schrader *11/26/2019*
Authorized Signature Date

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Homeless Health Initiatives: Guiding Principles

Board of Directors Meeting
December 5, 2019

Michael Schrader, Chief Executive Officer
TC Roady, Director, Regulatory Affairs and Compliance
Candice Gomez, Executive Director, Program Implementation

Agenda

- Current initiatives and Board direction
- California Advancing and Innovating Medi-Cal (CalAIM)
- Homeless Health allocation in light of CalAIM

Current Initiatives

Board-Approved Programs With $100 Million Homeless Health Reserve	Funding
Be Well OC Regional Mental Health and Wellness Hub	$11.4 million
Recuperative Care	$10.75 million
Respite Care	$250,000
Clinical Field Team Startup	$1.6 million
CalOptima Homeless Response Team	$6 million
Homeless Coordination at Hospitals	$10 million
CalOptima Day and Quality Improvement Program	$1.2 million
Federally Qualified Health Centers Expansion	$.6 million
Total Allocated	**$41.8 million**
Remaining Funding Available	**$58.2 million**

- Other Board-Approved Programs Supporting Homeless Health
  - Medication-Assisted Treatment: $6 million (IGT funds)
- Other Programs Pending Board Approval
  - Housing Supportive Services: $2.5 million (reallocated from reserve)

Board Actions and Directives on Homeless Health

- In June, the Board adopted a $60 million allocation for homeless health spending in four categories
  - Clinic health care services in all homeless shelters
  - Mobile health team response to all homeless providers
  - Residential support services and housing navigation
  - Recuperative care for those with chronic physical health issues
- Working with the Board's ad hoc committee, staff developed Guiding Principles and crosswalk to provide the Board with a tool to guide funding decisions
- CalAIM has the potential to affect homeless health spending in the future
  - Consider CalAIM's impact on Guiding Principles

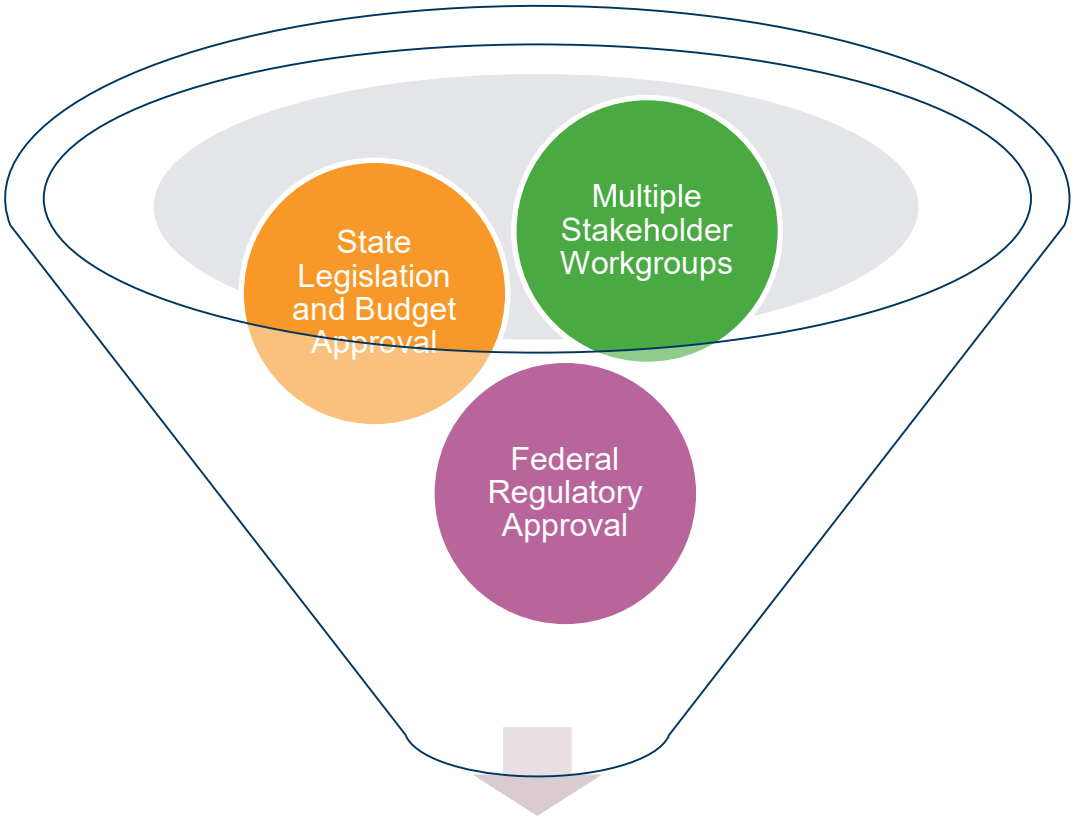
CalAIM Background

- On October 28, the Department of Health Care Services (DHCS) released CalAIM, a proposal with the potential to significantly impact the future Medi-Cal delivery system framework
  - Spans a five-year period from 2021 to 2025
  - Contains more than 20 core initiatives
  - Expands Medi-Cal managed care plans' responsibilities

- The proposal represents the start of a process that will include stakeholder engagement, and multiple federal and state approvals

CalAIM Process

- CalAIM is in the early stages of development
- CalAIM will evolve before reaching a final form for implementation starting January 1, 2021
  - ➢ Many layers of input will undoubtedly change the proposal



Final CalAIM Document

Five CalAIM Workgroups

Population Health/ Annual Enrollment	• Requires managed care plans to develop and maintain population health management strategies
Enhanced Care Management	• Explores implementation of an enhanced care management benefit and in lieu of services
Behavioral Health	• Considers integration of county-level mental health and substance use disorder programs
NCQA Accreditation	• Provides input on a proposal to require Medi-Cal managed care plans to obtain accreditation
Full Integration Plans	• Discusses full integration of physical health, behavioral health and oral health under one entity

Future CalAIM Implementation

- The various proposals have different effective dates, ranging from January 2021 to January 2025
  - Understanding the rules and regulations before and after implementation will be challenging

- With regard to CalOptima's Homeless Health Initiatives, three proposals (in their current form) have the most potential impact in the near term
  - Population Health Management
  - Enhanced Care Management
  - In Lieu of Services

Current State, Before CalAIM

- Programs that “bridge” to CalAIM
  - Health Homes Program (HHP)
    - Enhanced care management
    - Housing supportive services
  - Whole-Person Care (WPC)
    - Recuperative care
- Intergovernmental Transfer (IGT) 1–7 dollars
  - Enhanced services for Medi-Cal members
    - Reallocating funds toward housing supportive services
- IGT 8 dollars
  - Medi-Cal-covered services for Medi-Cal members
    - Enhanced hospital discharge planning
    - Transitions of care (under development with stakeholder group)

Future Possibilities, After CalAIM*

- Population Health Management (PHM)
  - Develop and maintain PHM programs compliant with NCQA requirements, and update and file annually with DHCS
  - Risk stratify populations (low-, medium- and high-risk) and have defined actions and programs to address population needs
  - Conduct initial member assessments and then reassessments on an annual basis
  - Offer basic, complex and enhanced care management

Subject to stakeholder input and CMS and DHCS approval

Future Possibilities, After CalAIM* (Cont.)

- Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
  - Statewide health plan benefit replacing HHP and WPC by January 1, 2021
  - Holistic, interdisciplinary approach to clinical and non-clinical needs of target populations
    - Individuals experiencing homelessness are specifically included as a target population
  - By July 2020, plans must submit transition plan moving from HHP and WPC to the ECM/ILOS model of care

Subject to stakeholder input and CMS and DHCS approval

Future Possibilities, After CalAIM* (Cont.)

- ILOS can only be covered if:
  - State determines that the service is a medically appropriate and cost-effective substitute for a typical service
  - The service is optional (beneficiaries are not required to use ILOS)
  - The service is authorized and identified in the state's Medi-Cal managed care plan contract

Menu of In Lieu of Services Options**
Housing transition navigation services
Housing deposits
Housing tenancy
Short-term post-hospitalization housing
Nursing facility transition/diversion
Recuperative care
Personal care and homemaker services
Respite care
Day habilitation programs
Home modifications
Meals/medically tailored meals
Sobering centers

***See CalAIM Appendix D for a detailed description of what is allowed under each of the above ILOS*

* *Subject to stakeholder input and CMS and DHCS approval*

CalAIM Advocacy

- California Association of Health Plans and Local Health Plans of California are actively participating in the CalAIM process
  - Managed care plans, including CalOptima, will be integral in shaping the eventual final CalAIM document
  - Managed care plans are generally very supportive of the direction CalAIM is headed

- Responding to the needs of Orange County's homeless population would be enhanced through adoption of certain current CalAIM proposals
  - CalOptima will advocate to this effect and pursue opportunities as available

Recommended Action

- Approve homeless health initiatives Guiding Principles and crosswalk as a framework for future funding allocations

HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES
December 5, 2019

Organizations across Orange County are actively responding to the local homeless crisis. CalOptima is participating by making improvements to the health care delivery system for homeless individuals. On April 4, 2019, the Board of Directors voted to commit $100 million in a restricted homeless health reserve. At that time, $40 million was directed to a range of specific initiatives, and $60 million was for unidentified new initiatives:

Projects *(as of April 4, 2019)*	**Allocated**	**Unallocated**	**Funding Category**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup Costs	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$6 million		IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)	$10 million		
New Initiatives		$60 million	
Total Reserve: $100 million	**$40 million**	**$60 million**	

In the months since, CalOptima has continued to consider program options, in part by welcoming input from community organizations and providers serving homeless individuals. On June 27, 2019, at a special Board meeting, the Board approved a proposal outlining $60 million in funding allocations for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers –$10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

The Board recognizes that the approved allocations allow room for interpretation and the possibility of executing new initiatives in various ways. Further, a recent state proposal, known as California Advancing and Innovating Medi-Cal (CalAIM), suggests significant changes to the Medi-Cal managed care landscape starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. To move forward with effective funding allocations in this dynamic environment, staff have developed Guiding

Principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns. Proposals consistent with the principles would be brought forward for consideration by the Board; proposals that are inconsistent would face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion, but internal and external audiences can use the principles to support initiatives that unify the community around our shared goal of better serving Orange County's homeless population.

GUIDING PRINCIPLES

Transparent and Inclusive

Inherent in CalOptima's response to the homeless crisis is a commitment to engage the community. Since beginning this effort and across several months, we have collaborated with Orange County Health Care Agency leaders, homeless advocates, community health center staff, provider representatives and countless others. CalOptima staff have and will continue to host meetings and forums, most recently adding a provider and hospital meeting series. Our interest in establishing these Guiding Principles starts from this place of inclusiveness.

- *CalOptima shall foster transparency in homeless health spending by regularly engaging stakeholders to gather ideas and feedback.*

Compliant and Sustainable

CalOptima has invested considerable time and money in understanding the legal and regulatory spending parameters related to health care delivery system enhancements for members who are homeless. In this environment, there are clear distinctions between funding sources that must be maintained. Intergovernmental Transfer (IGT) 1–7 dollars were permitted for enhancements to Medi-Cal services, but new IGT 8 dollars must be used according to different guidelines that restrict the spending to Medi-Cal-covered services. Furthermore, use of FY 2018–19 operating funds is similarly restricted to Medi-Cal-covered services for members, so expenditure of these dollars will be incorporated into CalOptima's rate development process. This would create sustainable funding for ongoing homeless health programs even after depletion of the Board-established homeless health reserve. However, the CalAIM proposal has the potential to expand Medi-Cal-covered benefits, which could broaden what CalOptima is permitted to fund for homeless health. This opportunity is under development, so until CalAIM is finalized, CalOptima must adhere to current rules. In any event, financial stewardship is one of CalOptima's core values, and our commitment is to spend on new homeless health initiatives in a fashion that complies with all applicable rules and appropriately builds our rates.

- *CalOptima shall spend the $60 million on allowable uses only, with the strict rule that IGT 8 and FY 2018–19 funds must be used for Medi-Cal-covered services for Medi-Cal members.*

Strategic and Integrated

CalOptima's effort to better serve members who are homeless is aligned with the strategic direction of state and federal regulators as well as industry trends. Population health initiatives recognize that certain populations need targeted interventions, and these programs can be integrated within the existing delivery system. For example, CalOptima's clinical field team program is designed to reconnect members with their medical homes not replace them. We appreciate the essential role of our hospital and health network partners and will purposefully seek ways to ensure new homeless health initiatives are integrated.

- *CalOptima shall support programs that honor the unique needs of the homeless population while integrating into the existing delivery system.*

Defined and Accountable

CalOptima is in new territory exploring ways to respond to the needs of homeless members. But our commitment to longstanding principles of quality and accountability has not changed. As we move forward, new programs will be carefully defined through Board-approved actions and subject to appropriate oversight and performance metrics. The CalOptima Board will hold itself accountable to ensure the implemented programs provide value and perform as anticipated, which may include establishing incentives for provider partners.

- *CalOptima shall identify measures of success and develop incentives to boost accountability in any new homeless health initiative.*

CROSSWALK: HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES AND FUNDING CATEGORIES

December 5, 2019

		Homeless Health Funding Categories			
		Clinic health care services in all homeless shelters	**Authorize mobile health team to respond to all homeless providers**	**Residential support services and housing navigation**	**Extend recuperative care for homeless individuals with chronic physical health issue**
Guiding Principles	**Transparent and Inclusive*** *Transparent planning that includes providers and other key stakeholders*	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: CalOptima and our health networks transparently and inclusively provide Medi-Cal members with case management and care coordination as appropriate. In addition, health networks will serve as CB-CMEs for HHP, with Illumination Foundation as an available vendor for housing navigation. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Separately, the IHSS, MSSP and PACE programs provide services in the member's home.	Consistent: Today, recuperative care is not currently a Medi-Cal benefit, apart from the WPC pilot to which CalOptima previously allocated funds for recuperative care. However, CalOptima is planning to advocate with providers and stakeholders through the CalAIM process for the state to make recuperative care a Medi-Cal benefit in 2021, upon the completion of the WPC pilot.
		*Assumes continued coordination of input from biweekly health network/hospital meetings with CalOptima Board Homeless Health Ad Hoc.			
	Compliant and Sustainable *Sustained Medi-Cal funding for CalOptima from DHCS*	Consistent: Continuing to pay for clinic services (Medi-Cal-covered services) for CalOptima Medi-Cal members at shelters would be sustainable in terms	Consistent: Continuing to pay for clinical field team services (Medi-Cal-covered services) for CalOptima Medi-Cal members would be sustainable in	Consistent: Case management and care coordination are covered benefits under the basic Medi-Cal program, and housing navigation is a	Inconsistent: Inconsistent today because recuperative care is not a Medi-Cal-covered service, except through the WPC pilot. Consequently, there

		of ongoing state funding.	terms of ongoing state funding.	covered benefit under HHP. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Consequently, there is sustainable funding within these parameters.	is no source of sustainable funding currently. However, the CalAIM process has the potential to broaden Medi-Cal-covered services to include recuperative care.
	Strategic and Integrated *Integration with CalOptima's contracted health care delivery system*	Consistent: Clinic services in homeless shelters should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Clinical field teams should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Case management and care coordination services are integrated into CalOptima's contracted health care delivery system. HHP CB-CMEs will also be integrated through health networks. The CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be integrated into the CalOptima system.	Consistent: If recuperative care becomes a Medi-Cal benefit following completion of the WPC pilot and/or implementation of CalAIM, CalOptima would integrate the benefit with our contracted delivery system of health networks and hospitals.
	Defined and Accountable *Specific deliverables and measures of success*	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: There is definition and accountability for health networks related to case management, care coordination and HHP CB-CME housing services. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be defined and accountable.	Consistent: If recuperative care becomes a Medi-Cal benefit, we will continue what the WPC pilot successfully started, including to have specific deliverables and measures of success (e.g., transitions to PSH).

Acronyms:
CalAIM = California Advancing and Innovating Medi-Cal
CB-CME = Community-Based Care Management Entity
HHP = Health Homes Program
IHSS = In-Home Supportive Services
MSSP = Multipurpose Senior Services Program
PACE = Program of All-Inclusive Care for the Elderly
PCP = Primary Care Physician
PSH = Permanent Supportive Housing
WPC = Whole-Person Care

CMS Adult Elective Surgery and Procedures Recommendations:

Limit all non-essential planned surgeries and procedures, including dental, until further notice

To aggressively address COVID-19, CMS recognizes that conservation of critical resources such as ventilators and Personal Protective Equipment (PPE) is essential, as well as limiting exposure of patients and staff to the SARS-CoV-2 virus. Attached is guidance to limit non-essential adult elective surgery and medical and surgical procedures, including all dental procedures. These considerations will assist in the management of vital healthcare resources during this public health emergency.

Dental procedures use PPE and have one of the highest risks of transmission due to the close proximity of the healthcare provider to the patient. To reduce the risk of spread and to preserve PPE, we are recommending that all non-essential dental exams and procedures be postponed until further notice.

A tiered framework is provided to inform health systems as they consider resources and how best to provide surgical services and procedures to those whose condition requires emergent or urgent attention to save a life, preserve organ function, and avoid further harms from underlying condition or disease. Decisions remain the responsibility of local healthcare delivery systems, including state and local health officials, and those surgeons who have direct responsibility to their patients. However, in analyzing the risk and benefit of any planned procedure, not only must the clinical situation be evaluated, but resource conservation must also be considered. These recommendations are meant to be refined over the duration of the crisis based on feedback from subject matter experts. At all times, the supply of personal protective equipment (PPE), hospital and intensive care unit beds, and ventilators should be considered, even in areas that are not currently dealing with COVID-19 infections. Therefore, while case-by-case evaluations are made, we suggest that the following factors to be considered as to whether planned surgery should proceed:

- Current and projected COVID-19 cases in the facility and region.
    - consider the following tiered approach in the table below to curtail elective surgeries. The decisions should be made in consultation with the hospital, surgeon, patient, and other public health professionals.
- Supply of PPE to the facilities in the system
- Staffing availability
- Bed availability, especially intensive care unit (ICU) beds
- Ventilator availability
- Health and age of the patient, especially given the risks of concurrent COVID-19 infection during recovery
- Urgency of the procedure.

Tiers	Action	Definition	Locations	Examples
Tier 1a	Postpone surgery/ procedure	**Low acuity surgery/healthy patient**- outpatient surgery Not life threatening illness	HOPD* ASC** Hospital with low/no COVID-19 census	-Carpal tunnel release -EGD -Colonoscopy -Cataracts
Tier 1b	Postpone surgery/ procedure	**Low acuity surgery/unhealthy patient**	HOPD ASC Hospital with low/no COVID-19 census	-Endoscopies
Tier 2a	Consider postponing surgery/procedure	**Intermediate acuity surgery/healthy patient-** Not life threatening but potential for future morbidity and mortality. Requires in-hospital stay	HOPD ASC Hospital with low/no COVID-19 census	-Low risk cancer -Non urgent spine & Ortho: Including hip, knee replacement and elective spine surgery -Stable ureteral colic -Elective angioplasty
Tier 2b	Postpone surgery/ procedure if possible	**Intermediate acuity surgery/unhealthy patient**-	HOPD ASC Hospital with low/no COVID-19 census	
Tier 3a	Do not postpone	**High acuity surgery/healthy patient**	Hospital	-Most cancers -Neurosurgery -Highly symptomatic patients
Tier 3b	Do not postpone	**High acuity surgery/unhealthy patient**	Hospital	-Transplants -Trauma -Cardiac w/ symptoms -limb threatening vascular surgery

*Hospital Outpatient Department
** Ambulatory Surgery Center
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Policy:	GG.1665
Title:	**Telehealth and Other Technology-Enabled Services**
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	*/s/ Michael Schrader 03/25/2020*
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. Addendum: COVID-19 Emergency Provisions

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-43-20

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

WHEREAS on March 30, 2020, I issued Executive Order N-39-20 to pave the way for a temporary expansion of the health care workforce ahead of an anticipated surge in the need for medical treatment, and related strain on the health care delivery system, caused by COVID-19; and

WHEREAS clinics, hospitals, and other health care facilities and health care providers must maximize the number of capable health care workers through the use of telehealth services to ensure that Californians impacted by COVID-19 are able to access medical treatment as necessary; and

WHEREAS it is imperative to reduce the spread of COVID-19 and protect health care workers, including through the use of telehealth services, where possible, for any reason (not limited to the diagnosis and treatment of COVID-19 or related conditions); and

WHEREAS health care facilities housing vulnerable populations, such as nursing homes and psychiatric facilities, require special measures to protect those populations from COVID-19 and ensure continuity of care; and

WHEREAS on March 17, 2020, the Office for Civil Rights in the U.S. Department of Health and Human Services issued guidance ("Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency," available at https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html) announcing that the Office, in the exercise of its enforcement discretion, will not impose penalties for noncompliance with regulatory requirements imposed under the HIPAA Rules, as to covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency; and

WHEREAS even in an emergency situation, covered entities must continue to implement reasonable safeguards to protect patient information against intentional or unintentional impermissible uses and disclosures. Further, covered entities and their business associates must apply the administrative, physical, and technical safeguards of the HIPAA Security Rule to electronic protected health information; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes, regulations, and certain local ordinances specified or referenced herein would prevent, hinder, or delay appropriate actions to prevent and mitigate the effects of the COVID-19 pandemic.

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NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and the statutes of the State of California, and in particular, Government Code sections 8567 and 8571, do hereby issue the following Order to become effective immediately:

IT IS HEREBY ORDERED THAT:

1) The requirements specified in Business and Professions Code section 2290.5(b), related to the responsibility of a health care provider to obtain verbal or written consent before the use of telehealth services and to document that consent, as well as any implementing regulations, are suspended.

2) The penalties specified in Civil Code section 56.35, as well as any cause of action arising out of section 56.35 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 56.35) are suspended as applied to inadvertent, unauthorized access or disclosure of health information during the good faith provision of telehealth services.

3) The administrative fines, civil penalties, and private right of action specified in Civil Code section 56.36, as well as any other cause of action arising out of section 56.36 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 56.36, as well as the authority to bring a civil action set forth in subdivision (f) of section 56.36) are suspended as applied to inadvertent, unauthorized access or disclosure of health information during the good faith provision of telehealth services.

4) The civil penalties for health care facilities and providers specified in Civil Code sections 1798.29 and 1798.82, related to the timely notification to patients of a breach of the security system, are suspended as applied to any breach resulting from inadvertent, unauthorized access or disclosure during the good faith provision of telehealth services. Any cause of action arising out of section 1798.29 or section 1798.82 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 1798.29 or section 1798.82) is likewise suspended as applied to inadvertent, unauthorized access or disclosure that occurs during the good faith provision of telehealth services.

5) The deadlines specified in Health and Safety Code section 1280.15, related to notification to the Department of Public Health and to patients of the unauthorized access or disclosure of health information, are extended from a period of 15 days to a period of 60 days when the unauthorized access or disclosure is related to the good faith provision of telehealth services. The administrative penalties specified in Health and Safety Code section 1280.15, related to unauthorized access or disclosure of health information, are suspended when the unauthorized access or disclosure occurs during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal or state law. Any cause of action arising out of section 1280.15 (including, but not limited to, any cause of action

arising out of the Unfair Competition Law that is predicated on section 1280.15) is likewise suspended as applied to unauthorized access or disclosure that occurs during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal or state law.

6) The administrative penalties for health care providers specified in Health and Safety Code section 1280.17, related to safeguards of health information, are suspended for health care providers as applied to any inadvertent, unauthorized access or disclosure of health information during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal or state law. Any cause of action arising out of section 1280.17 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 1280.17) is likewise suspended as applied to inadvertent, unauthorized access or disclosure that occurs during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal or state law.

7) The criminal penalties specified in Welfare and Institutions Code section 14100.2(h), related to persons who knowingly release or possess information about Medi-Cal beneficiaries, are suspended as applied to health care providers, health care facilities, and health care administrators for any inadvertent, unauthorized release of confidential information during the good faith provision of telehealth services. Any cause of action arising out of section 14100.2 (including, but not limited to, any cause of action arising out of the Unfair Competition Law that is predicated on section 14100.2) is likewise suspended as applied to health care providers, health care facilities, and health care administrators for any inadvertent, unauthorized release of confidential information during the good faith provision of telehealth services.

8) To the extent any provision of this Order suspends any penalty or other enforcement mechanism associated with the violation of any statute where such violation arises out of the good faith provision of telehealth services, such violation shall not constitute unprofessional conduct within the meaning of Article 10.5 of the Business and Professions Code or any other applicable law, or otherwise be cause for professional discipline.

9) Where the provision of telehealth services is conducted by a "covered health care provider" subject to the HIPAA Rules and described in the "Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency" ("Notification") issued by the Office for Civil Rights in the U.S. Department of Health and Human Services on March 17, 2020, that covered health care provider shall ensure that its delivery of telehealth services is consistent with that Notification. This paragraph does not impose any mandatory requirements beyond any mandatory requirements imposed by the Notification itself, except that where the Notification encourages particular measures to safeguard patient privacy, but does not require such measures, covered health care

providers shall give due consideration to such measures and shall endeavor to adopt them to the extent possible.

10) For purposes of this Order, "telehealth services" includes the use of telehealth services to engage in the provision of behavioral or mental health services, in addition to the use of telehealth services to engage in the provision of medical, surgical, or other health care services. This paragraph should be construed to ensure that the provisions of this Order apply to the provision of behavioral or mental health services the same extent that those paragraphs apply to other forms of health care.

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

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

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 3rd day of April 2020.

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

21. Consider Authorizing Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2021

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Candice Gomez, Executive Director, Program Implementation, (714) 246-8849

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer for Calendar Year 2021 (IGT 11):

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in IGT 11;
2. Pursuit of funding partnerships with the University of California-Irvine, First 5 Orange County Children & Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in IGT 11; and,
3. Development and execution by the Chief Executive Officer, with the assistance of Legal Counsel, of agreements with these entities and their designated providers as necessary to seek IGT 11 funds.

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 ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been received and IGT 10 funds will be distributed in two separate installments and are expected from the state in the spring and fall of 2021.

IGTs 1 through 7 funds were established based on retrospective payments for prior rate range years and were made available to CalOptima for the purpose of providing enhanced/additional benefits to existing CalOptima Medi-Cal beneficiaries, as represented to the Center for Medicare & Medicaid Services. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries. The IGT funds received under IGTs 1 through 7 have supported special projects that address unmet health care needs of CalOptima members, such as, but not limited to, vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for members who are homeless, and support for members through the Personal Care Coordinator (PCC) program.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between DHCS and CalOptima. Unlike previous IGTs (1-7), beginning with IGT 8, IGT funds are paid through capitation, and as such, may only be used in the same way that CalOptima currently uses its primary capitation funds; that is, for Medi-Cal medically necessary covered

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services and administrative expenses. These IGT capitation payments are also subject to all applicable requirements set forth in CalOptima's contract with DHCS. IGT 8 funds have been allocated to the Homeless Health Initiative. IGT 9 funds were allocated to the following focus areas: member access and engagement; quality performance; data exchange and support; and other priority areas. IGT 10 funds have not yet been received or allocated; CalOptima staff anticipates returning with recommendations on an allocation plan in a separate future Board action within the parameters of allowable expenditures. As previously indicated and per the direction of DHCS, the use of these funds is limited to covered Medi-Cal services for existing CalOptima members.

For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing Member's unmet health care needs.

Discussion

On November 4, 2020, CalOptima received notification from DHCS regarding the IGT 11 opportunity. CalOptima's proposal, along with the proposed funding entities' supporting documents, are due to DHCS no later than December 11, 2020.

The five eligible funding entities from the previous IGT transactions have been contacted regarding their interest in participation in IGT 11. All five funding entities have informally indicated that they are interested in participation in the IGT program this year. The formal DHCS-required Letter of Interest from the proposed funding entities is due to CalOptima by December 7, 2020 for delivery to DHCS by December 11, 2020. These entities are:

1. University of California, Irvine,
2. First 5 Orange County Children & Families Commission,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in IGT 11 and to authorize the Chief Executive Officer to enter into agreements with each of the five proposed funding entities submitting a letter of interest or their designated providers for the purpose of securing available IGT funds. Consistent with the prior IGT transactions for which funds have been received, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to the Board with additional information regarding the IGT 11 transaction and a proposed expenditure plan for CalOptima's share of the net proceeds at a later date.

Fiscal Impact

The recommended action to submit a proposal to DHCS and pursue funding partnerships to participate in IGT 11 is expected to generate one-time IGT revenue that will be invested in covered Medi-Cal

services for CalOptima members. The allocation and expenditure of CalOptima's share of IGT 11 funding will be addressed in separate Board actions.

Rationale for Recommendation

Consistent with the previous ten IGT transactions, submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Calendar Year 2021 (IGT 11). Also, consistent with the 2020-22 Strategic Plan, it would increase funding to support delivery of covered Medi-Cal services for existing CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Department of Health Care Services Voluntary Rate Range IGT Program Notification Letter

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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Attachment to the December 3, 2020 Board of Directors Meeting – Agenda Item 21

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
First 5 Orange County Children & Families Commission	1505 E. 17th Street, 230	Santa Ana	CA	92705
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
University of California, Irvine UCI Health	333 City Blvd. West, Suite 200	Orange	CA	92868

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State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOME
GOVERNOR

November 4, 2020

Nancy Huang, Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Calendar Year 2021 (January 1, 2021 – December 31, 2021) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Ms. Nancy Huang:

The Calendar Year 2021 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of January 1, 2021 through December 31, 2021.

DHCS shall not direct the MCP's expenditure of payments received under the Calendar Year 2021 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from

programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the Calendar Year 2021 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR CALENDAR YEAR 2021:

MCPs should refer to the estimated Calendar Year 2021 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the Calendar Year 2021 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that the estimated Contribution (Non-Federal Share) amounts are based on "draft" capitation rates (as of September 2020) and estimated member months, and the actual amounts may change based on finalized rates and updated enrollment estimates.

If an MCP elects to participate in the Calendar Year 2021 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the Calendar Year 2021 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.
    2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
    3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for Calendar Year 2021. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
    4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the Calendar Year 2021 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Calendar Year 2021 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday**, December 11, 2020**.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Friday, *December 11, 2020***. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov and Vivian.Beeck@dhcs.ca.gov. ***Failure to***

submit all required documents by the due date may result in exclusion from the Calendar Year 2021 Voluntary Rate Range Program.

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the Calendar Year 2021 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 420-5730 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

DocuSigned by:
Beau Bouchard
5AA717EBC57749D...

November 3, 2020

Beau Bouchard
Staff Services Manager II
Financial Management Section B
Capitated Rates Development Division

Attachments

cc: Richard Sanchez, Interim Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST

Rafael Davtian
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Davtian:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2021 through December 31, 2021. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Calendar Year 2021 (January 1, 2021 – December 31, 2021) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2021 (January 1, 2021 through December 31, 2021)

Provider Name:
County:
Health Plan:

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than December 11, 2020.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2019 - June 30, 2020.

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient (not including pharmacy services billed by a pharmacy on a pharmacy claim)**				$	$
Pharmacy services billed by a pharmacy on a pharmacy claim**				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received, for dates of service from July 1, 2019 - June 30, 2020.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2019 - June 30, 2020 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. Please provide the following information:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

If No, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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CalOptima - Orange (HCP 506)
Rate Range Program - Calendar Year 2021

	Total
Total Funds Available	$ 119,431,201
Federal Match	$ 79,243,476
Governmental Funding Entity's Portion	$ 40,187,725

Rate Categories[1]	Estimated Member Months[2]	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage[3]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund	Governmental Funding Entity Portion	Non-Federal Share Percentage
Child - non MCHIP	2,407,396	$ 76.63	$ 82.55	$ 5.92	$ -	$ 5.92	$ 14,251,784	$ 7,085,282	49.72%
Child - MCHIP	1,288,307	$ 76.63	$ 82.55	$ 5.92	$ -	$ 5.92	$ 7,626,777	$ 2,670,158	35.01%
Adult - non MCHIP	1,154,545	$ 207.03	$ 220.52	$ 13.49	$ -	$ 13.49	$ 15,574,812	$ 7,852,801	50.42%
Adult - MCHIP	32,332	$ 207.03	$ 220.52	$ 13.49	$ -	$ 13.49	$ 436,159	$ 159,154	36.49%
ACA Optional Expansion	3,147,397	$ 318.69	$ 338.31	$ 19.62	$ 4.91	$ 14.71	$ 46,298,210	$ 5,371,534	11.60%
SPD	496,069	$ 583.04	$ 617.65	$ 34.61	$ -	$ 34.61	$ 17,168,948	$ 8,646,463	50.36%
SPD/Full-Dual (non-CCI)	16,639	$ 199.33	$ 209.12	$ 9.79	$ -	$ 9.79	$ 162,896	$ 79,764	48.97%
LTC (non-dual) - non MCHIP	17,585	$ 11,174.85	$ 11,481.41	$ 306.56	$ -	$ 306.56	$ 5,390,858	$ 2,810,064	52.13%
LTC (non-dual) - MCHIP	6	$ 11,174.85	$ 11,481.41	$ 306.56	$ -	$ 306.56	$ 1,839	$ 711	38.66%
LTC/Full-Dual (non-CCI)	0	$ 7,188.46	$ 7,351.94	$ 163.48	$ -	$ 163.48	$ -	$ -	N/A
Whole Child Model	131,598	$ 1,455.50	$ 1,550.63	$ 95.13	$ -	$ 95.13	$ 12,518,918	$ 5,511,794	44.03%
	8,691,874	$ 254.56	$ 270.08	$ 15.52	$ 1.78	$ 13.74	$ 119,431,201	$ 40,187,725	33.65%

[1]The supplemental payments (Maternity, BHT and HCBS) and CCI population are not included in the rate range calculation.

[2] Member months were based on 102% of Mercer's Calendar Year 2021 estimated member months (as of 8/31/2020).

[3] Other Departmental Usages decreases available rate range funding.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
22. Consider Authorizing Amendment to Ancillary Contract with the Illumination Foundation

Contacts
Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116
Pallavi Patel, Director, Process Excellence (657) 235-6941

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's contract with the Illumination Foundation to exercise the first of three one-year extension options, extending the contract agreement until December 31, 2021.

Background/Discussion
The Health Homes Program (HHP), authorized under the Federal Patient Protection and Affordable Care Act, is designed to improve member health outcomes and reduce care costs. As an added layer of support on top of the standard Medi-Cal benefits, the HHP is intended to provide members with care coordination services and guidance for accessing many community-based services as well. Members are eligible for HHP based on certain criteria, including complex medical needs and chronic conditions. Specifically, members must have at least two or more of the following conditions:

- Chronic obstructive pulmonary disease
- Diabetes
- Traumatic brain injury
- Chronic or congestive heart failure
- Coronary artery disease
- Chronic kidney disease
- Hypertension
- Major depression disorders
- Bipolar disorder
- Psychotic disorder
- Substance abuse
- Asthma

In addition to the above conditions, qualifying criteria include at least one (1) inpatient hospital stay during the past year, three (3) or more emergency department visits during the past year, or chronic homelessness. HHP is also accessible to members who are already part of the California Children's Services or the Whole Person Care programs. The goal of HHP is to help members in need of assistance with navigating health, behavioral, and social services systems to identify, support and achieve members' health goals.

Authorized by the Board of Directors on June 7, 2018, through an amendment to CalOptima's primary agreement with the California Department of Health Care Services (DHCS), HHP was implemented on

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July 1, 2020. Under the program, CalOptima is responsible for overall administration, including development of a provider network that furnishes the variety of HHP services. The main services include:

- Housing navigation and sustainability
- Care coordination
- Individual and family support services
- Assistance with moving
- Linking members with community resources for assistance with living expenses
- Accompaniment to provider appointments

Following a Request for Proposal (RFP) process, staff selected the Illumination Foundation to provide housing navigation and sustainability and accompaniment services for CalOptima Direct and CalOptima Community Network members enrolled in HHP. The Illumination Foundation is a nonprofit organization that has been contracted with CalOptima since January 2020, when the first phase of HHP implementation began. Illumination Foundation's current contract with CalOptima expires on December 31, 2020. Staff is now recommending that the Board authorize staff to exercise the first of three one year extension options to extend this contract through December 2021.

Fiscal Impact

The recommended action to extend the Illumination Foundation contract for the period of January 1, 2021, through June 30, 2021, is a budgeted item under the CalOptima Fiscal Year 2020-21 Operating Budget. Management will include expenses related to the recommended contract extension for the period of July 1, 2021, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

Approval of the extension and rate adjustment for the Illumination Foundation contract will ensure continuity of services provided for CalOptima's HHP members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Previous Board Action dated October 3, 2019; "Consider Authorizing Contract with Vendor for Health Homes Program Select Services for Accompaniment and Housing Related Services"
3. Previous Board Action dated June 7, 2018; "Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program"

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Illumination Foundation	1091 N. Batavia St	Orange	CA	92867

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Authorizing Contract with Vendor for Health Homes Program Select Services for Accompaniment and Housing Related Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve recommended vendor Illumination Foundation for HHP select services for accompaniment and housing related services;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with the recommended vendor, effective January 1, 2020; and
3. In the event CalOptima and Illumination Foundation are unable to reach agreeable contract terms within thirty (30) days, authorize the CEO, with the assistance of Legal Counsel, to enter into an agreement with the next qualified bidder, Maxim Healthcare Services, for HHP select services for accompaniment and housing related services.

Background

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. The intent of HHP is to improve member outcomes and reduce health care costs. In California, Assembly Bill 361 (2013) authorizes implementation of the Health Home Program. HHP, which is an entitlement benefit, is being implemented in selected counties in a phased in implementation approach, with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. On June 7, 2018, the CalOptima Board of Directors (Board) authorized an amendment to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) to incorporate implementation of the HHP. Implementation in Orange County is expected to be effective no sooner than January 1, 2020 for CalOptima Medi-Cal members with eligible chronic physical conditions and substance use disorders (SUD), and no sooner than July 1, 2020 for CalOptima Medi-Cal members with Serious Mental Illness (SMI).

To support development of HHP, Section 2703 of the ACA provides enhanced funding to states. Rather than the standard Medicaid funding (Federal 50%/State 50%), the Center for Medicare & Medicaid Services (CMS) will fund 90% for the first two years following implementation, effective for each phase. California Assembly Bill 361 requires budget neutrality and that no state general funds are used towards the program. As such, the California Endowment is funding the remaining 10% of funds for HHP. After the first two years, the funding returns to the standard Medicaid funding (Federal 50%/State 50%).

Pursuant to the DHCS Program Guide and All Plan Letter 18-012: Health Homes Program Requirements, MCPs will be responsible for overall administration, including development of HHP network. DHCS also published an HHP Program Guide that outlines the responsibilities of the MCPs

and Community-Based Care Management Entities (CB-CMEs). Per the DHCS requirements, HHP services are to be provided and coordinated through the network of CB-CMEs. In addition, CB-CMEs are responsible for coordinating care with members, providers and other agencies as appropriate. HHP Program Guide requires the following six core service categories for members enrolled in HHP:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Under HHP, members will be eligible for new services, including housing navigation, housing tenancy sustainability, and accompaniment to clinical appointments. CalOptima plans to contract with a vendor for these HHP select services.

Discussion

New HHP services include accompaniment to clinical appointments, housing transition services and tenancy sustaining services. Following CalOptima's standard RFP process in accordance with CalOptima Policy GA.5002: Purchasing, CalOptima staff conducted a Request For Proposal (RFP) processes to procure vendors for these new HHP select services beginning January 1, 2020. The new HHP select services are provided in-person and do not include direct medical care services. An HHP select services vendor is not required to be registered with the Medi-Cal program. Health networks, as CB-CMEs, will have the ability to contract with the selected vendor(s).

In response to the RFP, CalOptima received responses from:

- American Family Housing
- Illumination Foundation
- Maxim Healthcare Services

The submitted proposals were reviewed by an internal evaluation team consisting of representatives from Business Integration, Medical Affairs, Strategic Development, Network Management, Contracting, Vendor Management, Operations, Finance, Behavioral Health and Information Services.

The recommended vendor will provide the HHP select services in-person and participate in the member's care team meetings. The vendor is expected to capture, track, and report all services and coordinated efforts to CalOptima and care team members as appropriate. Additionally, the vendor will make the same HHP select services available to the health networks either through CalOptima's contract or a separate contract with the individual health network.

Vendor	Final Weighted Score
American Family Housing	11.00
Illumination Foundation	22.35
Maxim Healthcare Services	16.60

Based on the final weighed scores, staff recommends contracting with the Illumination Foundation for select HHP services.

Founded in 2008, Illumination Foundation is a 501 (c)(3) non-profit organization dedicated to the mission of providing targeted and interdisciplinary services. Illumination Foundation has experience working with similar populations as HHP eligible members. They believe that every person has an intrinsic right to home, health, and dignity. Their direct client care staff includes case managers, housing navigators, behavioral health therapists, substance use counselors, and a variety of healthcare workers (LVNS, RNs, nurse practitioners) who follow clients as they access emergency shelter, recuperative care, and housing related services with the overall goal to achieve longer-term health and housing outcomes. The agency has served more than 52,825 individuals since its inception.

Fiscal Impact

The anticipated implementation date for HHP in Orange County is January 1, 2020. Management has included projected revenues and expenses for HHP in the CalOptima Fiscal Year 2019-20 Operating Budget and will for future operating budgets. Total actual revenue and expenses for HHP will depend on the number of members that choose to participate in the program. Based on projected enrollment and draft rates received from DHCS on April 2, 2018, CalOptima is projected to receive $26.3 million in funding for HHP over a three-year period.

Since this is a new program for CalOptima, there is the possibility that the rate development assumptions applied by DHCS may be materially different from CalOptima's actual utilization and expenses. Staff will closely monitor both utilization and expenses and will continue to work with DHCS to ensure that Medi-Cal revenue will be sufficient to support the program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated implementation of Health Homes Program, effective January 1, 2020, for CalOptima Medi-Cal members with eligible chronic physical conditions and SUD, and July 1, 2020, for members with SMI.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program
3. Department of Health Care Services Medi-Cal Health Homes Program, Program Guide 7/1/19
4. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements
5. HHP Select Services RFP

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment to October 3, 2019 Board of Directors Meeting – Agenda Item 16

Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip
American Family Housing	15161 Jackson Street	Midway City	CA	92655
Illumination Foundation	1091 N. Batavia St.	Orange	CA	92867
Maxim Healthcare Services	7227 Lee Deforest Drive	Columbia	MD	21046

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

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

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM

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

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

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

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

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

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

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

Medi-Cal Health Homes Program
Program Guide
7/01/19

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I. Introduction

The Medi-Cal Health Homes Program: Program Guide (Program Guide) is intended to be a resource for Medi-Cal Managed Care health plans (MCPs) in the development, implementation, and operation of the Health Homes Program (HHP). The Program Guide includes a brief synopsis of the HHP, identifies all HHP requirements, and identifies the documentation MCPs must submit to the Department of Health Care Services (DHCS) as part of the required HHP readiness review. The Program Guide refers to additional guidance documents, when applicable.

The Medicaid Health Home State Plan Option is afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Enhanced federal matching funds of 90% are available for two years.

In California, Assembly Bill 361 (AB 361) amended the Welfare and Institutions Code to add Sections 14127 and 14128 (W&I Code) which authorizes DHCS, subject to federal approval, to create an ACA Section 2703 HHP for members with chronic conditions. The W&I Code provides that the provisions will be implemented only if federal financial participation (FFP) is available and the program is cost neutral regarding State General Funds. It also requires DHCS to ensure that 1) an evaluation of the program is completed; and 2) a report is submitted to the appropriate policy and fiscal committees of the Legislature within two years after implementation of the program.

The Program Guide has five main sections (Infrastructure, Eligibility, Services, Network, and General Operations) and an appendix. Each section describes the program components and the requirements for those components.

The Program Guide contains the Health Homes Program: Medi-Cal Managed Care Plan Readiness Checklist (Readiness Checklist) in Appendix D. The Readiness Checklist identifies the specific components that MCPs are required to provide to DHCS and identifies the process DHCS will use to determine when the specific components are due to DHCS. The Program Guide provides additional guidance and context regarding HHP readiness requirements.

II. HHP Infrastructure

A. Organizational Model

DHCS' HHP implementation will utilize California's Medi-Cal Managed Care (Managed Care) infrastructure as the foundational building block. HHP services will be provided through the Managed Care delivery system to members enrolled in Managed Care. Managed Care serves approximately 85 percent of full scope Medi-Cal members and is an available choice for all full-scope Medi-Cal members statewide. The small percentage of Medi-Cal Fee-For-Service (FFS) members who meet HHP eligibility criteria may enroll in a Medi-Cal MCP to receive HHP services. HHP services will not be provided through the FFS delivery system.

The MCPs will leverage existing communication with their provider networks to facilitate the care planning, care coordination, and care transition coordination requirements of HHP, including assignment of each HHP member to a primary care provider. The MCPs' existing communication and reporting capabilities will be utilized to perform health promotion, encounter reporting, and quality of care reporting. MCPs also have existing relationships with the Medi-Cal county specialty mental health plans (MHPs) in each county to facilitate HHP care coordination.

The HHP will be structured as a health home network functioning as a team to provide care coordination. This network includes the MCP, one or more Community-Based Care Management Entities (CB-CMEs), and contractual or non-contractual relationships with other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed (taken together as the HHP). The HHP network will be developed to meet the following goals:

- Ensure that sufficient HHP funds are available to support care management at the point of care in the community
- Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available as needed
- Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- Forge new relationships with community provider care management entities, where possible and appropriate
- Utilize community health workers in appropriate roles.

The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long Term Services and Supports (LTSS), oral health services, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, ED visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between the MCP and the CB-CME, either through direct provision of HHP services,

or through contractual or non-contractual arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

1) Medi-Cal Managed Care Plan Responsibilities

HHP MCPs will be responsible for the overall administration of the HHP. They will have an HHP addendum to an existing contract with DHCS. Payment will flow from DHCS to the MCP and from the MCP to the CB-CMEs for the provision of HHP services. The MCP may also use HHP funding to pay providers, including but not limited to, the member's primary care physician, behavioral health providers, or other specialists, who are not included formally on the CB-CME's multi-disciplinary care team, for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the Health Action Plan (HAP). These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).

The MCP will have strong oversight and will perform regular auditing and monitoring activities to ensure that case conferences occur, the HAP is updated as health care events unfold, and all other HHP care management requirements are completed.

The MCP's care management department can be leveraged to train, support, and qualify CB-CMEs. (MCPs currently perform similar monitoring, training and auditing with MCP-delegated entities that have care management responsibilities under Cal MediConnect and other programs.)

MCP utilization departments will assist the CB-CMEs with information on admissions and discharges, and ensure timely follow-up care. MCP health care informatics analytics teams will provide meaningful, actionable data with identification of complex members and care gaps and other pertinent data that the health plan network can access. This will be provided to the CB-CMEs to assist with HAP care planning and ongoing goals for the member.

Many MCPs are exploring housing options to provide immediate housing post discharge and find permanent housing for members who are experiencing homelessness. Stakeholders include the health plan, hospitals, local housing authorities, and community-based organizations. Achieving stable housing for HHP members is a noted best practice from the national experience for achieving meaningful improvements in health and program cost effectiveness.

In counties selected for HHP implementation, Medi-Cal MCPs (Medicaid only benefit plans) are required to participate in HHP and serve as an HHP MCP. DHCS will work with these organizations to prepare for the implementation of HHP and to determine network adequacy and readiness.

2) Duties

MCPs will be expected to perform the following duties/responsibilities to the extent their information systems allow or through other available methods:

- Attribute assigned HHP members to CB-CMEs;
- Sub-contract with CB-CMEs for the provision of HHP services and ensure that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals;

- Notify the CB-CMEs of inpatient admissions and ED visits/discharges;
- Track and share data with CB-CMEs regarding each member's health history;
- Track CMS-required quality measures and state-specific measures (see *Reporting Template* and *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting,* or later *document*);
- Collect, analyze, and report financial measures, health status and other measures and outcome data to be reported during the State's evaluation process (see *Reporting Template*)
- Provide member resources (e.g. customer service, member grievances) relating to HHP
- Add functionality to the MCP's customer service line and 24/7 nurse line or other available call line so that members' HHP needs are also addressed (e.g. equip nurse line with educational materials to train them about HHP, nurse line receives the updated list of HHP members and their assigned care coordinator, etc.)
- Receive payment from DHCS and disperse funds to CB-CMEs through collection and submission of claims/encounters by the CB-CME and per the contractual agreement made between the MCP and the CB-CME
- Establish and maintain a data-sharing agreement with other providers, with whom MCP shares HHP member health information, that is compliant with all federal and state laws and regulations
- Ensure access to timely services for HHP members, including seeing HHP members after discharge from an acute care stay.
- Encourage participation by HHP members' MCP contracted providers who are not included formally on the CB-CME's multi-disciplinary care team, but who are responsible for coordinating with the CB-CME care coordinator to conduct case conferences and to provide input to the HAP. These providers are separate and distinct from the roles outlined for the multi-disciplinary care team (see Multi-Disciplinary Care Team).
- Develop CB-CME training tools as needed or preferred, in addition to DHCS-provided training
- Develop CB-CME reporting capabilities
- Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

3) Community Based Care Management Entity Responsibilities

CB-CMEs will serve as the frontline provider of HHP services and will be rooted in the community. MCPs will certify and select organizations to serve as CB-CMEs through a process similar to current MCP provider certification and will contract with selected entities. DHCS will not require MCP use of a standardized assessment tool. DHCS will provide general guidelines

and requirements, including examples of best practice tools that the MCP can use at their option to select, qualify, and contract with CB-CMEs.

The MCP's development of a network of CB-CMEs should seek to promote HHP goals, with particular attention to the following goals:

- Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;
- Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
- Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate; and
- OPTIONAL - Utilizing community health workers in appropriate roles (for more information, see Multi-Disciplinary Care Team below).

CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the MCP, for ensuring that an assigned HHP member receives access to HHP services. It is also the intent of the HHP to provide flexibility in how the CB-CMEs are organized. CB-CMEs may subcontract with other entities or individuals to perform some CB-CME duties. Regardless of subcontracting arrangements, CB-CMEs retain overall responsibility for all CB-CME duties that the CB-CME has agreed to perform for the MCP, either through direct CB-CME service or service the CB-CME has subcontracted to another provider. DHCS encourages MCPs and CB-CMEs to utilize this flexibility, where needed, to achieve HHP goals, and in particular the four network goals noted above.

In most cases, the CB-CME will be a community primary care provider (PCP) that serves a high volume of HHP eligible members. If the CB-CME is not the member's MCP-assigned PCP, then the MCP and the CB-CME must demonstrate how the CB-CME will maintain a strong and direct connection to the PCP and ensure the PCP's participation in HAP development and ongoing coordination. For all members, and in all areas, the MCP must demonstrate that it is maximizing the four network goals noted above to the full extent possible through its network development and HHP policies. Regardless of how HHP networks are structured by a MCP within a county, it is expected that all HHP members will receive access to the same level of service, in accordance with the service tier that is appropriate for their needs and HHP service requirements.

DHCS' readiness review will include a detailed review of the MCP's HHP network. In situations in which the MCP can demonstrate that there are insufficient entities rooted in the community that are capable or willing to provide the full range of CB-CME duties, the MCP may perform needed CB-CME duties to fill a demonstrated service gap. As an alternative, the MCP may subcontract with other entities to perform these duties. In addition, the MCP may provide, or subcontract with another community-based entity to provide, specific CB-CME duties to assist a CB-CME to provide the full range of CB-CME duties when this MCP assistance is the best organizational arrangement to promote HHP goals. If the MCP utilizes this flexibility, the MCP must demonstrate to DHCS that it is maximizing the four network goals noted above to the

extent possible, and how it will maintain a strong and direct connection between HHP services and the primary care provider.

The MCP may allow an individual community provider to become a CB-CME after the implementation date of the HHP in their county if the community provider requires additional time to develop readiness to take on some, or all, of the CB-CME duties. The MCP may also allow a CB-CME to expand the range of the CB-CME's contracted CB-CME duties over time as readiness allows.

CB-CMEs that MCPs contract with to deliver HHP care coordination services are not required to be enrolled as Medi-Cal providers, so long as the entities in question are not providing medical and/or clinical services in their function as an HHP CB-CME to Medi-Cal members participating in the Program.

4) Community-Based Care Management Models

The main goal of the HHP is Comprehensive Care Management. The MCP, acting as administrator and providing oversight, will build an HHP network in which a member can choose the CB-CME they want for their care coordination. Given specific challenges in certain areas, including the shortage of primary care and specialist providers, technology infrastructure/adoption, and the large Medi-Cal population, a single model is not practical. Assessments of potential HHP providers, and MCP knowledge of available resources in their areas, will form the basis for determining whether the provider's HHP-eligible members are best served by Model I, II, or III below.

The three community-based care management models below are acceptable for MCP network development and address the realities that exist in various areas of the state regarding available providers. The three models will allow the flexibility to ensure service to all HHP members throughout the diverse geographic regions in California, regardless of location and type of provider empanelment. Further, all three will allow increased care coordination to occur as close to the point of care delivery as possible in the community.

Model I

The first and ideal model embeds care coordinators on-site in community provider offices, acting as CB-CMEs. The expectation is that the community provider will employ these staff, but in some cases they may be employed by the MCP. This model will serve the great majority of HHP members because most HHP eligible individuals are served by high-volume providers in urban areas. The MCP will complete a provider assessment to determine 1) the extent to which the community provider will need to recruit and hire additional staff to meet the HHP care coordinator resource requirements, and 2) what CB-CME duties the community provider can, and is willing to, perform. The HHP will only utilize Model II or III where the provider assessment indicates that Model I is not viable.

Model II

The second model addresses the smaller subset of eligible members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site. For this model, the care management would be handled by another community-based entity or a staff member within

the existing MCP care management department, which will act as the CB-CME. This model will handle HHP members who are not assigned to a county clinic or medical practice under Model I.

Model III

The third model serves the few members who live in rural areas and are served by low-volume providers. In this hybrid model, care coordinators located in regional offices, utilizing technology and other monitoring and communication methods, such as visiting the member at their location, will become CB-CMEs who can be geographically close to rural members and/or those members who are assigned to a solo practitioner who may not have enough membership to meet Model I or II.

B. Staffing

1) Care Coordinator Ratio

The aggregate minimum care coordinator ratio requirement is 60:1 for the whole enrolled population (in each of the MCPs' counties if the MCP has more than one county) as measured at any point in time.

To develop the aggregate population care coordinator ratio requirement, DHCS assumed that (after two years):

- *Tier 1 – 20% of population; care coordinator ratio of 10:1*
- *Tier 2 – 30% of population; care coordinator ratio of 75:1*
- *Tier 3 – 50% of population; care coordinator ratio of 200:1*

2) Multi-Disciplinary Care Team

The multi-disciplinary care team consists of staff employed by the CB-CME that provides HHP funded services. DHCS requires the team members listed in Table 1 below to participate on all multi-disciplinary care teams. The team will primarily be located at the CB-CME organization, except as noted above regarding model flexibility. The MCP may organize its provider network for HHP services according to provider availability, capacity, and network efficiency, while maximizing the stated HHP goals and HHP network goals. This MCP network flexibility includes centralizing certain roles that could be utilized across multiple CB-CMEs – and particularly low-volume CB-CMEs – for efficiency, such as the director and clinical consultant roles. An HHP goal is to provide HHP services where members seek care. Staffing and the day-to-day care coordination should occur in the community and in accordance with the member's preference.

In addition to required CB-CME team members, the MCP may choose to also make HHP-funded payments to providers that are not explicitly part of the CB-CME team, but who serve as the HHP member's physical and/or behavioral health service providers, for participation in case conferences and information sharing in order to support the development and maintenance of the HHP member's HAP. As an example, an MCP could use HHP care coordination funding to pay a member's specialist provider, who is not a contracted member of the CB-CME Multi-Disciplinary Care Team, for the time they spend participating in a case conference with the HHP care coordinator for the purpose of completing the member's HAP. The MCP may make such payments directly to the providers or through their CB-CME.

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm-reduction practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

C. Health Information Technology/Data

Health Information Technology (HIT)/Health Information Exchange (HIE) are important components of information sharing in the HHP.

MCPs should consider the following potential uses of HIT/HIE (developed by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

1) Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management –standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement.
2) Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information.
   - Telehealth services including remote patient monitoring.
3) Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
   - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
   - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.
4) Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.
5) Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence).
   - Ability to electronically refer patients to necessary services.

Organizations that are covered by the Meaningful Use requirements should utilize EHR/HIT/HIE to meet the applicable goals noted above, where possible. Organizations that are not covered by Meaningful Use may need a Medi-Cal MCP to support the achievement of applicable goals where possible. In some areas relatively few providers have EHRs; there is limited interoperability between the systems; and, where there is an HIE in the area, the configuration may not be designed for the HHP requirements. If the technology environment does not fully support the EHR/HIT/HIE activities noted above in some geographic areas, or with certain providers, the MCP will determine procedures to share information that is critical for HHP services through other methods.

III. HHP Member Eligibility

A. Target Population

The HHP is intended to be an intensive set of services for a small subset of Medi-Cal members who require coordination at the highest levels. DHCS worked with a technical expert workgroup to design eligibility criteria that identify the highest-risk three to five percent of the Medi-Cal population who present the best opportunity for improved health outcomes through HHP services. These criteria include both 1) a select group of International Classification of Diseases (ICD)-9/ICD-10 codes for each eligible chronic condition, and 2) a required high level of acuity/complexity.

B. HHP Eligibility Criteria and the Targeted Engagement List

Using administrative data, DHCS will develop a Targeted Engagement List (TEL) of Medi-Cal MCP members who are eligible for the HHP based on the DHCS-developed eligibility criteria noted below. The TEL will be refreshed every six months using the most recent available data. The MCP will actively attempt to engage the members on the TEL. (See Member Assignment, for more information on MCP activity to engage eligible members.)

To be eligible for the HHP, a member must be full-scope, have no share of costs, and meet the following eligibility criteria. See Appendix B for *Targeted Engagement List data specification document* and specific ICD 10 codes that define these eligible conditions:

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

The TEL may include other criteria that are intended to ensure that HHP resources are targeted to Medi-Cal members who present the best opportunity for improved health outcomes through HHP services. The DHCS TEL is intended to be used by MCPs as a list of people who are likely to be eligible for the program based on the data available to DHCS; it is not, on its own, a comprehensive eligibility list.

Acuity Eligibility Criteria

Eligibility for HHP requires that members have the specified conditions and at least one of the four acuity criteria listed above. MCPs must have a process to verify eligibility as part of the enrollment process. MCPs can do this through reviews of the MCPs data and/or through other methods including discussion/assessment with the member or the member's providers. This additional verification is not only to confirm that the member meets eligibility, but also that they do not have exclusionary criteria such as enrollment in another duplicative care management program or being "well managed." For example, a member's qualifying utilization may have been for something unrelated to management of a chronic condition, such as maternity.

MCPs should make a preliminary eligibility determination based on their data prior to proceeding with proactive outreach and engagement. MCPs may rely on the TEL to verify that the member meets the eligibility criteria for having the eligible chronic conditions and the acuity criteria relating to having three or more of the eligible chronic conditions; however, the MCP should verify utilization acuity criteria (within 12 months) using the MCP's own data.

MCPs are required to review their own data for members who are on the TEL and should not proactively outreach members whose qualifying utilization is: 1) only found in the oldest four months of the TEL look-back period; and 2) unrelated to the HHP chronic conditions. MCPs may also apply their own additional prioritization policies upon approval from DHCS.

At the point in time when the MCP makes this data-driven preliminary eligibility determination, the member will be considered eligible for the program regardless of how long it takes the member to agree to enroll. The member may be enrolled for at least one month to complete the member assessment and care plan process. If additional information is determined during the assessment/care plan process that negates prior eligibility data or confirms an exclusionary criteria, then the member will be disenrolled.

Homeless Eligibility Criteria

Chronic homelessness for HHP is defined in W&I Code section 14127(e), and states *"a chronically homeless individual means a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years. For purposes of this article, an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing, as defined in Section 50675.14 of the Health and Safety Code, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her*

residence." For the purpose of verifying HHP acuity eligibility criteria, the portion of this definition which states "with a condition limiting his or her activities of daily living" is satisfied by verification that the member has one of the HHP-eligible conditions. No further assessment of activities of daily living limitation is required to establish that the member meets the portion of this eligibility acuity criterion underlined above. In addition, a member meets the HHP chronically homeless acuity eligibility criteria if the member meets either the W&I Code section 14127(e) definition or the Housing and Urban Development (HUD) definition.

People Excluded from Targeted Engagement List

The following exclusions will be applied either through MCP data analysis for individual members or through assessment information gathered by the Community-Based Care Management Entity (CB-CME) (see *Reporting Template-Instructions* for additional information):

- Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria
- Members whose condition management cannot be improved because the member is uncooperative
- Members whose behavior or environment is unsafe for CB-CME staff
- Members determined to be more appropriate for an alternate care management program

IV. Health Home Program Services

This section describes the six HHP services. HHP arranges for and coordinates interventions that address the medical, social, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices available to HHP members.

All HHP engagement and services can be provided to members and family/support persons through e-mails, texts, social media, phone calls, letters, mailings, community outreach, and, to the extent and whenever possible, in-person meetings where the member lives, seeks care, or is accessible. Communication and information must meet health literacy standards and trauma-informed care standards and be culturally appropriate.

A. Comprehensive Care Management

Comprehensive care management involves activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). The HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, trauma-informed care, social supports, and, as appropriate for individuals experiencing homelessness, housing. The HAP is based on the needs and desires of the member and will be reassessed based on the member's progress or changes in their needs. It will also track referrals. The HAP must be completed within 90 days of HHP enrollment.

Comprehensive care management may include case conferences to ensure that the member's care is continuous and integrated among all service providers.

Comprehensive care management services include, but are not limited to:

- Engaging the member in HHP and in their own care
- Assessing the HHP member's readiness for self-management using screenings and assessments with standardized tools
- Promoting the member's self-management skills to increase their ability to engage with health and service providers
- Supporting the achievement of the member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines
- Completing a comprehensive health risk assessment to identify the member's needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services
- Developing a member's HAP and revising it as appropriate
- Reassessing a member's health status, needs and goals
- Coordinating and collaborating with all involved parties to promote continuity and consistency of care
- Clarifying roles and responsibilities of the multi-disciplinary team, providers, member and family/support persons

1) Care Management Assessment Tools

To the extent possible and reasonable, DHCS will align new requirements for care management methods and tools with those currently used by MCPs for care coordination. MCPs have extensive experience administering Health Risk Assessments and developing care plans.

MCPs may use current Cal MediConnect or Seniors and Persons with Disabilities (SPD) care management tools, such as the Health Risk Assessment and Individualized Care Plan, as a base for developing health assessments and completing the HAP for HHP members. For the implementation of HHP, any assessment or planning elements that are required in the HHP and are not already included in an existing tool and/or process must be added to the existing MCP assessment and planning tools. Such elements could include an assessment of social determinants of health, including an indicator of housing instability, a need for palliative care, and trauma-informed care needs.

The HAP is defined as the Individualized Care Plan with the inclusion of any elements specific to HHP. When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the care coordinators for all HHP members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities such as county agencies or volunteer support entities, the care coordinator will work with the HHP member and their family/support persons to develop a HAP.

2) Duties

MCPs in partnership with CB-CMES must be able to carry out the following comprehensive care management services:

Member Engagement and Support

a. MCPs must ensure that CB-CMEs accomplish the following:
    1) Engage the member in the HHP and their own care
    2) Assess the HHP member's readiness for self-management using standardized screenings and assessments with standardized tools
    3) Track and promote the member's self-management skills to increase their ability to engage with health and service providers
    4) Support the achievement of the member's self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines

Member Assessment

a. MCPs/CB-CMEs must have a process for assessing and reassessing the member to identify their needs in the areas of physical health, mental health, substance use, oral health, palliative care, trauma-informed care, and social services. The process should identify:
    1) How their tools align with current tools used for the defined population and avoid unnecessary duplication of assessment?
    2) How trauma-informed care best practices will be utilized?
    3) Whether the assessment process and HAP are standard across the CB-CMEs or whether variations exist.
b. MCPs/CB-CMEs must have a process and tools for developing the member's HAP and revising, as appropriate
c. MCPs/CB-CMEs must develop and use the HAP and screening and assessment tools, and develop processes for:
    1) How the HAP is shared with other providers and if it can be shared electronically; and
    2) How the HAP will track referrals and follow ups.

Coordination

a. MCPs/CB-CMEs must have a process for integrating community social supports, long term support services, mental health, substance use disorder services, palliative care, trauma-informed care, oral health, and housing services into a member's HAP
b. MCP must ensure that the CB-CMEs:
    1) Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and
    2) Clarify roles and responsibilities of the multi-disciplinary team, providers, HHP member, and family/support persons.
c. MCPs must have policies and procedures to ensure that members are not receiving the same services from another state care management program (see non-duplication of care coordination services for more information).

B. Care Coordination

Care coordination includes services to implement the HHP member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with current MCP care coordination activities, but will require a higher level of service than current

MCP requirements. Care coordination may include case conferences in order to ensure that the member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete CB-CME/care coordinator training as discussed in Appendix C.

Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

1) Member Support

- Working with the member to implement their HAP
- Assisting the member in navigating health, behavioral health, and social services systems, including housing
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Identifying barriers to the member's treatment and medication management adherence
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Assisting in attainment of the member's goals as described in the HAP
- Encouraging the member's decision making and continued participation in HHP
- Accompanying members to appointments as needed

2) Coordination

- Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, care planning, medications usages and side effects
- Creating and promoting linkages to other services and supports
- Helping facilitate communication and understanding between HHP members and healthcare providers

MCPs in partnership with CB-CMEs must develop, and ensure the implementation of, policies and procedures to support CB-CME coordination efforts to:

a. Maintain frequent, in-person contact between the member and the care coordinator when delivering HHP services. Minimum in-person visits for the aggregated population is 260 visits per 100 enrolled members per quarter. DHCS used the following assumptions to develop the aggregate population visit requirement listed above:
    i. After two years, the population equals: 20% in tier 1, 30% in tier 2, 50% in tier 3
    ii. Tier 1 – two in-person visits per month
    iii. Tier 2 – 1 in-person visit per month
    iv. Tier 3 – 1 in-person visit per quarter
b. Ensure members see their PCP within 60 days of enrollment in HHP. This is a recommended best practice only – not service requirement.
c. Ensure availability of support staff to complement the work of the Care Coordinator.
d. Ensure availability of providers with experience working with people who are chronically homeless.
e. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

f. Link eligible individuals who are homeless or experiencing housing instability to permanent housing, such as supportive housing.
g. Maintain an appointment reminder system for members. This is a recommended best practice only – not a service requirement.
h. Identify and take action to address member gaps in care through:
    i. Assessment of existing data sources for evidence of care appropriate to the member's age and underlying chronic conditions
    ii. Evaluation of member perception of gaps in care
    iii. Documentation of gaps in care in the member case file
    iv. Documentation of interventions in HAP and progress notes
    v. Findings from the member's response to interventions
    vi. Documentation of discussions of members care goals
    vii. Documentation of follow-up actions, and the person or organization responsible for follow-up

C. Health Promotion

Health promotion includes services to encourage and support HHP members to make lifestyle choices based on healthy behavior, with the goal of motivating members to successfully monitor and manage their health. Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

Health promotion services include, but are not limited to:

- Encouraging and supporting health education for the member and family/support persons
- Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management
- Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences
- Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences
- Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care

D. Comprehensive Transitional Care

Comprehensive transitional care includes services to facilitate HHP members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member's care coordinator and tracking of member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member's transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member's HAP
- Providing transition support to permanent housing

E. Individual and Family Support Services

Individual and family support services include activities that ensure that the HHP member and family/support persons are knowledgeable about the member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the member and family/support persons to manage the member's condition and assisting them to access these support services.

Individual and family support services may include, but are not limited to:

- Assessing the strengths and needs of the member and family/support persons
- Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management
- Connecting the member to self-care programs to help increase their understanding of their conditions and care plan
- Promoting engagement of the member and family/support persons in self-management and decision making
- Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices
- Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals
- Accompanying the member to clinical appointments, when necessary
- Identifying barriers to improving the member's adherence to treatment and medication management
- Evaluating family/support persons' needs for services

F. Referral to Community and Social Supports

Referral to community and social support services involves determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources, and following up with the members.

Community and social support referral services may include, but are not limited to:

- Identifying the member's community and social support needs
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member
- Providing member with information on relevant resources, based on the member's needs and interests.
- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports
- Following up with the member to ensure needed services are obtained
- Coordinating services and follow-up post engagement
- Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require
- Providing Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing
- Providing Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy

V. Health Homes Program Network

A. MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities:

a. Develop and implement criteria for network sufficiency determination, including county-wideness and number of projected members
b. Develop an adequate network of Community-Based Care Management Entities (CB-CMEs) in each of the MCP's implemented counties for HHP to serve enrolled members
c. Design and implement a process for determining the qualifications of organizations to meet CB-CME standards and for providing support for CB-CMEs, including:
    1. Identify organizations who meet the CB-CME standards
    2. Provide the infrastructure and tools necessary to support CB-CMEs in care coordination
    3. Gather and share HHP member-level information regarding health care utilization, gaps in care and medications
    4. Provide outcome tools and measurement protocols to assess CB-CME effectiveness
d. Integrate community entities focused on services to individuals experiencing homelessness into the care model and, if applicable, the multi-disciplinary care team; meet the State legislation requirement to ensure availability of providers with experience working with individuals who are chronically homeless.

e. Engage with community and social support services by building new, or enhance existing, relationships with programs, services, and support organizations to provide care to members, including but not limited to:
    1. County specialty mental health plans;
    2. Housing agencies and permanent housing providers; and
    3. Individual Housing and Tenancy Sustaining Services.
f. Contract with CB-CMEs for the provision of HHP services, including outlining the MCP and CB-CME roles and responsibilities, and ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, including the network development goals.
g. Have methods to ensure compliance with HHP requirements throughout the network, including portions of the network contracted through delegated entities.
h. Ensure the development of a communication and feedback strategy for all members of the HHP care team, including the member and their family/support persons, to ensure information sharing occurs. Encourage all of the HHP member's providers who supply input to the HAP and coordinate with the CB-CME care coordinator to conduct case conferences, including with those whom may not be formally included on the CB-CME's multi-disciplinary care team.
    1. If the CB-CME is not the member's MCP-assigned PCP, the MCP must have policies and procedures for ensuring: the MCP/CB-CME maintains a strong and direct connection to the PCP and PCP's participate in HAP development and ongoing coordination.
i. Have strong oversight and perform regular auditing and monitoring activities to ensure that all care management requirements are completed

1) Administration

a. Attribute assigned HHP members to CB-CMEs, providing for increased care coordination as close to the member's usual point of care delivery as possible in the community. HHP members must be notified of their CB-CME options.
b. Receive payment from DHCS and disperse funds to CB-CMEs. Have policies and procedures regarding:
    1. The process for how an MCP determines that the appropriate level of services are provided and documented by CB-CMEs in accordance with the contract and service requirements; and
    2. The process/structure/tiering (if used) for payments to CB-CMEs.

2) Data Sharing and Reporting

a. Develop reporting capabilities and methodologies
b. Establish and maintain data-sharing agreements that are compliant with all federal and state laws and regulations, and when necessary, with other providers
c. Notify CB-CMEs of inpatient admissions and emergency department (ED) visits/discharges
d. Track and share data with CB-CMEs regarding each member's health history
e. Establish procedures for hospitals participating under the Medicaid State Plan or a waiver of such plan for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated HHP providers. However, HHP primarily uses the TEL to identify and refer members to HHP.

3) Training and Education

a. Develop and offer learning activities that will support CB-CMEs in effective delivery of HHP services
b. Develop CB-CME training tools, as needed, to supplement DHCS-developed tools.
c. Ensure participation of the CB-CME and MCP staff delivering HHP Services in DHCS-required CB-CME and care coordinator training and learning collaboratives.

B. CB-CME Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with W&I Code HHP requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP member, to enhance access to services for HHP members and families where geographic or other barriers exist and according to member choice;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by the MCP, according to the CB-CME contract with the MCP;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and MCP and other providers involved in the HHP member's care.

C. CB-CME Certification

Organizations must be one of the following types of organizations and be able to meet the qualifications above and perform the duties below to be authorized to serve as a CB-CME:

- Behavioral health entity
- Community mental health center
- Community health center
- Federally qualified health center
- Rural health center
- Indian health clinic
- Indian health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group

- SUD treatment provider
- Provider serving individuals experiencing homelessness
- Other entities that meet certification and qualifications of a CB-CME, if selected and certified by the MCP

D. CB-CME General Duties

CB-CMEs will be expected to perform the following duties/responsibilities:

- Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;
- Implement systematic processes and protocols to ensure member access to the multi-disciplinary care team and overall care coordination;
- Ensure person-centered health action planning that coordinates and integrates all of the HHP member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;
- Collaborate with and engage HHP members in developing a HAP and reinforcing/implementing/reassessing it in order to accomplish stated goals;
- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP member's health action goals, conducting case conferences as needed in order to ensure that the HHP member care is integrated among providers;
- Support the HHP member in obtaining and improving self-management skills to prevent negative health outcomes and to improve health;
- Provide evidence-based care;
- Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;
- Support HHP members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;
- Accompany the HHP member to critical appointments (when necessary and in accordance with MCP HHP policy);
- Provide service in the community in which the HHP member lives so services can be provided in-person, as needed;
- Coordinate with the HHP member's MCP nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP member; and
- Provide quality-driven, cost-effective HHP services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

VI. General HHP Operations

A. Non-Duplication of Care Coordination Services

MCPs must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving HHP care coordination services. The process should include: 1) checking available MCP data; and 2) asking members as part of

both the in-person member assessment during the eligibility/enrollment process and the assessment/care plan process.

The Targeted Engagement List (TEL) does not include members who are participating in the following programs:

- 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH);
- County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);
- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month; and
- Hospice.

Below is a summary of how HHP intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: 1) Members can receive services through both HHP and the other program; 2) Members must choose HHP or the other program; and 3) Members cannot receive HHP services.

1) Members Can Receive Services through BOTH HHP and the Other Program

- 1115 Waiver Whole Person Care Pilot Program
  Members participating in a Whole Person Care (WPC) Pilot Program may also be eligible for the HHP. DHCS has released specific guidance related to the interaction between the Health Homes Program and the WPC Pilot Program which can be found in Appendix K of this Program Guide.

- California Children's Services
  Children who are enrolled in the Children's Services program are eligible for the HHP.

- Specialty Mental Health and Drug Medi-Cal
  DHCS recognizes that coordination of behavioral health services will be a major component of HHP. HHP services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, trauma-informed care, oral health, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California HHP structure of MCPs and CB-CMEs, it is expected that direct HHP services for HHP members will primarily occur at the CB-CMEs, even though MCPs may play a role. Therefore, it is important that CB-CMEs that have HHP members who receive behavioral health services have the capability to support the various needs of their members.

  For HHP members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented CB-CME is an appropriate setting for their HHP services. These CB-CMEs would typically be affiliated with an MCP.

  DHCS and stakeholders have noted that HHP members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary HHP services from their MHP's contracted provider acting as a designated CB-CME. To

facilitate care coordination for HHP members through a MHP-designated CB-CME, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform CB-CME HHP responsibilities through a contract with the MCPs in the county at the discretion of the MCP. This type of entity would perform the CB-CME HHP responsibilities for an HHP-eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated CB-CME instead of a CB-CME affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the CB-CME.

2) Members Must Choose HHP OR the Other Program

- Targeted Case Management
  County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and is duplicative of HHP. Members who are receiving TCM services have a choice of continuing TCM services or receiving HHP services.

  However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of HHP. The HHP provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

- 1915(c) Waiver Programs
  1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for HHP. There are comprehensive care management components within these programs that are duplicative of HHP services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving HHP services.
  The 1915(c) HCBS waiver programs include:
  HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH).

- Cal MediConnect or Fee-for-Service Delivery Systems
  Members who are eligible for both Medi-Cal and Medicare are eligible for the HHP. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the HHP. However, HHP is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for-Service delivery systems to receive all their Medi-Cal services, including HHP services, through a regular Medi-Cal Managed Care Plan.

- Other Comprehensive Care Coordination Programs
  Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of HHP services, including programs that are operated or overseen by the MCP. Examples include, but

are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

3) Members CANNOT Receive HHP Services

- Nursing Facility Residents and Hospice Recipients
  Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the HHP.

B. HHP Outreach Requirements

MCPs will be responsible for engaging HHP-eligible members, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria. Engagement of eligible HHP members will be critical for the program success. MCPs will link HHP members to one of the MCP's contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider (PCP) is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions.

1) MCP Duties/Responsibilities

MCPs must have the ability to perform the following duties/responsibilities or delegate to CB-CMEs and provide appropriate oversight.

a. Capacity
   Have the capacity to engage and provide services to eligible members, including:
   1) Establish an engagement plan with appropriate modifications for members experiencing homelessness;
   2) Evaluate the TEL provided by DHCS;
   3) Attribute assigned HHP members to CB-CMEs;
   4) Ensure the engagement of members on the targeted engagement list;
   5) Secure and maintain record of the member's consent to participate in the program (which can be verbal); and
   6) Provide member resources (e.g. customer service, member grievance process) relating to HHP.

b. Engagement Process
   1) Have policies and procedures for identifying, locating, and engaging HHP-eligible members.
   2) Use the following strategies for engagement as appropriate and to the extent possible: mail; email; social media; texts; telephone; community outreach; and in-person meetings where the member lives, seeks care, or is accessible.
   3) Show active, meaningful and progressive attempts at member engagement each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face-to-face, mail, electronic, telephone), follow-up if the member presents to another partner in the HHP network, or using claims data to contact providers the member is known to use. Examples of acceptable engagement include:

a. Letter to member followed by phone call to member
b. Phone call to member, outreach to care delivery partners and social service partners
c. Street level outreach, including, but not limited to, where the member lives or is accessible

4) Establish a process for reviewing and excluding people from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines of having no substantial avoidable utilization or be enrolled in another acceptable care management program – see Reporting Template-Instructions for definition);
5) Report Members determined not appropriate for the HHP, along with a reason code, to DHCS.
6) DHCS will evaluate the MCP enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the targeted engagement list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.
7) Include housing navigators in the engagement process, at the MCP's discretion
8) Document the member engagement process
9) Develop a methodology and criteria used by the MCP or the CB-CME to stratify high, medium and low need members
10) Develop educational materials or scripts that you intend to develop to engage the member.
11) Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma-informed care standards
12) Have policies and procedures for the following:
    a. Required number and modalities of attempts made to engage member
    b. MCP's protocol for follow-up attempts
    c. MCP's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate

c. Assignment

MCPs will link HHP members to one of their contracted CB-CMEs and ensure the HHP member is notified. If the HHP member's assigned primary care provider is affiliated with a CB-CME, the HHP member will be assigned to that CB-CME, unless the member chooses another CB-CME or a more appropriate CB-CME is identified given the member's individual needs and conditions. MCP's and/or CB-CME's notification will inform the HHP member that they are eligible for HHP services, and identify their MCP and CB-CME. This notification will explain that HHP participation is voluntary, members have the opportunity to choose a different CB-CME, and HHP members can discontinue participation at any time. It will also explain the process for participation. In counties where multiple MCPs are available, the HHP member may change their MCP once per month in accordance with current MCP choice policies.

C. Priority Engagement Group

After the MCP has screened people who are inappropriate for HHP from the TEL based on the HHP requirements, MCPs are required to create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for priority engagement status will be at the MCP's discretion (upon approval by DHCS).

D. Referral

HHP services must be made available to all full scope Medi-Cal members without a share of cost who meet the DHCS-developed eligibility criteria, including those members dually eligible for Medicaid and Medicare. Providers, health plan staff, or other, non-provider community entities/care providers may refer eligible members to the member's assigned MCP to confirm if the member meets the eligibility criteria to receive HHP services. The Targeted Engagement List will be the primary method for identifying and engaging eligible HHP members. Referrals are more likely necessary in the situation of a new Medicaid member who may not have the Medi-Cal claims history that identifies them as HHP eligible. Provider referral forms will indicate that the provider has verified that the member meets the HHP eligibility criteria. The provider will submit the referral form to the MCP for confirmation. MCP confirmation is required before an individual is deemed an HHP member and may receive HHP services from a CB-CME.

E. Consent

The member will be considered enrolled in the HHP once the member has given either verbal or written consent to participate in the program. The MCP or CB-CME will secure consents by the member to participate in HHP and authorize release of information to the extent required by law. Either the MCP or the CB-CME must maintain a record of these consents.

F. Disenrollment

If an eligible member has, or develops, an exclusionary criterion, cannot be engaged within a specified period, chooses not to participate, or fails to participate actively in HHP planning and coordination, the HHP member will be disenrolled from the HHP, and the MCP will discontinue CB-CME HHP funding for that member. Additionally, if the MCP determines that the member's eligible chronic conditions have become well-managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status – the HHP member will be disenrolled and the MCP will discontinue CB-CME HHP funding for that member.

A Notice of Action (NoA) Letter is required in all situations except for when an eligible member chooses not to participate. The eligible member may choose to participate in the HHP at any time.

G. Risk Grouping

The MCP will ensure that HHP member acuity will inform appropriate provision of HHP services. For example, MCP program criteria may include three, or more, risk groupings of the HHP members. Members in the higher acuity risk groupings (tiers) will receive more intensive HHP services. In addition, the HHP will include requirements to address the unique needs of members experiencing homelessness, as specified in AB 361.

H. Mental Health Services

MCPs will develop or amend existing Memoranda of Understanding with county Mental Health Plans (MHPs) to address HHP-specific information. DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018) to address the HHP-specific information that MCPs must include in new, or amended, MOUs. This MOU will be submitted to DHCS prior to the start of HHP implementation for the Serious Mental Illness or Serious Emotional Disturbance (SMI) population. Please see Appendix D - Readiness Requirements and Checklist for information on this deliverable.

I. Housing Services

MCPs will work with community resources to ensure seamless access to the delivery of housing support services. MCPs or contracted CB-CMEs must provide housing navigation services, not just referrals to housing. A Housing Navigator is required to be part of the HHP care team for members experiencing homelessness. HHP members must receive the following services:

1) Individual Housing Transition Services

Housing transition services assist beneficiaries with obtaining housing, such as individual outreach and assessments. These services include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
- Assisting with the housing application process. Assisting with the housing search process;
- Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- Ensuring that the living environment is safe and ready for move-in;
- Assisting in arranging for and supporting the details of the move; and
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2) Individual Housing and Tenancy Sustaining Services

Housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the roles, rights and responsibilities of the tenant and landlord;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

To the extent applicable, housing-based case management services provided to HHP members shall be consistent with the Housing First core components as described in Senate Bill (SB) 1380 Mitchel, Chapter 847, Statutes of 2016). Engagement to members potentially eligible for HHP or the provision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one or more of the DHCS defined HHP exclusionary criteria. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of members' lives, where members are engaged in nonjudgmental communication regarding drug and alcohol use. Members should be offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if they so choose.

The HHP does not provide direct funding for housing. However, DHCS encourages MCPs to partner with housing organizations that incorporate the Housing First model into their case management and housing navigation services offered to members and to prioritize connecting HHP members with permanent housing options, when appropriate and available. For example, plans might explore collaborating with community-based organizations that are Housing First compliant, implement a requirement that housing services be provided consistent with Housing First components, encourage enhanced coordination with coordinated entry and assessment systems and/or allow receipt of referrals from the homeless crisis response system entities.

The goal is to integrate Housing First principles and components in an effort to enhance the provision of meaningful individual housing and tenancy-sustaining services to enrolled members.

J. Training

MCPs are required to ensure that the MCP and CB-CME staff who will be delivering HHP services receive the required HHP training prior to participating in the administration of the HHP. See Appendix C for training requirements.

K. Service Directory

MCPs or CB-CMEs must ensure a directory of community services and supports is developed, maintained, and is made available to all care coordinators to inform referring members to social services. The community services directory may be sourced from existing directories so long as it is available as a resource for CB-CMEs and care coordinators. This type of directory may be maintained by either the MCP or the CB-CME; however, the contracted MCP will ensure its availability.

L. Quality of Care

MCPs must incorporate HHP into existing quality management processes.

MCPs must have the capacity to collect and track information used to manage and evaluate the program, including tracking quality measures, and collecting, analyzing, and reporting financial measures, health status and other measures and outcome data to be reported for the State's evaluation process. The MCP will report core service metrics and the recommended core set of health care quality measures established by CMS, as well as the three utilization measures identified by CMS to assist with the overall federal health home evaluation. MCPs must report on the measures listed in the *Reporting Template, and provide* encounters for all HHP services.

M. Cultural Competency, Educational and Health Literacy

MCPs must incorporate HHP into existing policies and procedures related to ensuring that services, communication, and information provided to members are culturally appropriate, and meet health literacy, reading, harm-reduction, and trauma-informed care standards.

N. Member Communication

MCPs must incorporate HHP into existing policies and procedures regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers) into account in communicating with enrollee. DHCS and DMHC will review member materials from Knox-Keene plans through the usual process and criteria. DHCS will use a parallel process for non-Knox-Keene plans.

All notices to be sent by the MCP to Medi-Cal beneficiaries regarding the provision of HHP services will be submitted to DHCS for review.

Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. MCPs may use the DHCS HHP Member Handbook as an optional resource for examples of "best practice" member messaging (though the Handbook messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

MCPs must maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.

O. Members Experiencing Homelessness

MCPs must incorporate HHP-specific information into the appropriate policies and procedures for homeless members, including special provider and service requirements criteria (to achieve homeless experience requirements and other requirements per AB 361 and SB 1380), and engagement processes.

P. Reporting

MCP must have the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP encounters for services provided by the MCP and the CB-CMEs. See Appendix G (*Reporting Template);* and the *Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting,* or later, for details.

CMS has established a core set of seven required health care quality measures and three utilization measures (see *Reporting Template* and *document* for details). Additional details can be found in the CMS technical specifications and resource manual. These measures were identified by CMS to assist with the overall federal health home evaluation.

MCPs will utilize the Supplemental Payment process to report members enrolled in HHP and to initiate capitation payments. See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information.

VII. Appendix

A. Appendix A – Example of an Acceptable Model Outreach Protocol

This Model Outreach Protocol is only offered as one example of a protocol that would be acceptable. It is meant to give the MCP ideas about how they might want to design their outreach protocols with the CB-CMEs. The details of this protocol are at the discretion of the MCP, as long as their protocol broadly meets DHCS' intent as stated in the body of the Program Guide and the Readiness Checklist.

SAMPLE PROTOCOL

The Medi-Cal managed care plan (MCP) will send an initial "Welcome Packet" to HHP-eligible members in accordance with their engagement process. After the initial packet is sent, the CB-CMEs will follow up with their HHP-eligible members through phone calls, in-person visits, and other modalities. Each CB-CME or the MCP will attempt to contact the member **five times** within 90 days after the initial packet is sent using various modes of communication (letters, calls, in-person meetings, etc.).

If the CB-CME does not have the capacity to conduct outreach to eligible members, MCP care coordination staff, including community health workers, will conduct the outreach to these members and note the outreach attempts in the members' record.

After five attempts, the CB-CME and the MCP will note the challenges with the active outreach and remind the PCP to discuss the HHP with the member at the next PCP visit. If the member declines HHP enrollment at the PCP visit, this will be noted in the EHR and the MCP will be notified.

If the CB-CME or the MCP learns that the contact information is out of date, efforts will be made to update that information using recent provider utilization data and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations. The CB-CME will also review members' housing history and work with the MCP Housing Program Manager to determine if that member can be reached at an alternative housing site or through a community-based organization.

CB-CMEs will track all outreach attempts within a three month intensive outreach period after the initial welcome letter is sent. The MCP will require that each outreach attempt and the outcome of each attempt be documented in the member's record in the HHP care management system and reported back to the MCP and DHCS. All outreach and engagement attempts will be evaluated by the care coordination team every 30 days within this three month period. The MCP will create policies and procedures for tracking and evaluating outreach and engagement efforts.

If a member declines participation in the HHP, or if their PCP determines that the member is not a good candidate for the HHP (using categories determined and provided by DHCS), this will be noted in the record in the HHP care management system to avoid repeated outreach

attempts. Members who do not enroll in the HHP will be noted, tracked in the MCP's data system and reported to DHCS. Members who graduate from the program will be disenrolled, which will be noted in the record, tracked in the data system, and reported to DHCS.

The MCP will create a mechanism for CB-CMEs and PCPs to identify potential HHP members who are not on the targeted engagement list and who meet the diagnostic and acuity criteria but not the utilization criteria. These individuals may be excellent candidates for the program to help prevent future avoidable health care utilization. In general, MCP will require CB-CMEs to justify the inclusion of the referred member into the program or onto the targeted engagement list. This would be reviewed by a medical director and/or nurse manager with experience in intensive case management to see if the member qualifies for the HHP or if they might be better served by another case management program, and if the rationale provided by the CB-CME or PCP justifies engagement and enrollment in the program.

Staff and Providers

The MCP will train MCP and CB-CME staff who may interact with HHP members, including customer service staff, 24-hour nurse line staff, and provider representatives, to ensure all member- and provider-facing staff are knowledgeable about the HHP, can answer questions and refer participating or eligible members or providers to the appropriate staff. MCP staff, CB-CME staff, providers and community providers are required to participate in webinars and trainings required by DHCS.

The MCP will work to educate all contracted providers, including providers at contracted CB-CMEs and providers from smaller clinics whose patients will receive HHP services through MCP care coordinators.

There will be on-the-ground community health workers who work in the local community and will visit members at their homes or community-based organizations where the members receive services. The MCP has made significant investments in developing this team of community health workers and they will be a key part of success in engaging and educating members on HHP.

Materials

The MCP will work with DHCS to educate providers, beneficiaries and key stakeholders to ensure strong member engagement and participation. The MCP will use outreach and education materials (flyers, brochures, sample email content, sample scripts, etc.) that are approved by DHCS. If the MCP is licensed by DMHC, these materials should additionally be filed with DMHC for review, as applicable. The MCP will also use existing communication channels to promote outreach and education opportunities for providers and members, such as informational webinars, trainings and tele-town halls.

At a minimum, the MCP will develop the following materials:

- Call scripts for Customer Service and 24-hour Nurse Advise Line;
- Member "Welcome Packet," including outreach letters and brochures;

- Appointment reminder letters for both medical and care coordination appointments;
- Content for both the member and provider sections of the MCP website; and
- Training guides for the MCP and CB-CME staff who interface with providers and members.

All member-facing materials for HHP will meet DHCS requirements for cultural competency and health literacy standards.

B. Appendix B – Targeted Engagement List Process

The Targeted Engagement List (TEL) Process identifies the Medi-Cal members that are the most appropriate candidates for the enhanced care coordination services in the Health Home Program (HHP). The TEL is sent to each participating Managed Care Plan (MCP) so that they can initiate engagement activities. This document provides additional details for the criteria and steps used in the TEL Process.

The data source for the TEL Process is DHCS's Data Warehouse. The Data Warehouse contains service level detail for most Medi-Cal programs, including managed care encounters, Fee-For-Service claims, Short-Doyle Mental Health services, Drug-Medi-Cal services, and others. MEDS eligibility information available in the Data Warehouse is also used in the TEL Process.

TEL Process – There are four main steps in the TEL Process, as follows:

1. SPA Eligibility Requirements for Chronic Condition Disease Identification – During the 24 months prior to the running of the TEL, if a member has at least two separate services on different dates for any of the following conditions it will be considered a chronic condition for the TEL. HHP chronic conditions include Asthma, Bipolar Disorder, Chronic Kidney Disease (CKD), Chronic Liver Disease, Chronic Obstructive Pulmonary Disease (COPD), Chronic or Congestive Heart Failure, Coronary Artery Disease, Dementia, Diabetes, Hypertension, Major Depression Disorders, Psychotic Disorders (including Schizophrenia), Substance Use Disorder, and Traumatic Brain Injury. The specific ICD-10 diagnosis codes for each chronic condition are listed below. The TEL process uses the primary and secondary diagnosis during the disease identification process.

2. SPA Eligibility Requirements for Chronic Condition Criteria. A member meets the chronic condition criteria if they have:
   2.1. Chronic Condition Criteria #1: At least two of the following: Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic or Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, Substance Use Disorder.
   2.2. Chronic Condition Criteria #2: Hypertension and one of the following: COPD, Diabetes, Coronary Artery Disease, Chronic or Congestive Heart Failure.
   2.3. Chronic Condition Criteria #3: One of the following: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders (including Schizophrenia).
   2.4. Chronic Condition Criteria #4: Asthma

3. SPA Eligibility Requirements – Acuity – These parameters ensure that potential HHP members are high utilizers of health services. A member must meet one of these acuity factors:

3.1. A high chronic condition predictive risk level (operationalized as three or more of the HHP eligible chronic conditions) or
3.2. At least one inpatient stay (not required to be related any particular condition*) in the 16-month period prior to the running of the TEL. (The inpatient stay algorithm is aligned with industry standards and the HEDIS inpatient algorithm) or
3.3. Three or more Emergency Department (ED) visits (not required to be related to any particular condition*) in a 16-month period prior to the running of the TEL. (The ED algorithm is aligned with industry standards and the HEDIS ED algorithm) or
3.4. Chronic Homelessness (there are no data parameters for this criteria. Members who only meet eligibility through this criteria will be identified solely through provider referral and MCP prior authorization)

* MCPs have the option to adjust this requirement.

4. HHP Enrollment Targeting and Exclusions – This step starts with the Medi-Cal members that meet the SPA chronic conditions and acuity eligibility requirements and determines if the members meet any of the specific program enrollment targeting and exclusionary criteria.:

a) Members that meet the eligibility requirements are excluded from the TEL, and <u>are excluded from participation in HHP unless their status changes</u>, if the members are identified as:

- Nursing Facility Residents
- Hospice Recipients
- Members with TCM
- Members in 1915 (c) programs
- Members in Fee-For-Service
- Members in PACE, SCAN, or AHF
- Members in Cal MediConnect

b) Members that meet the eligibility requirements are not included on the TEL (but could be enrolled through referral) if the members are identified as:

- Dually eligible members
- Members in CCS or GHPP
- Members with ESRD

TEL and TEL Supplement Reporting

The members that meet the eligibility requirements for chronic conditions and acuity will be reported to the managed care plans (MCPs) in either the TEL or the TEL Supplement. The TEL will contain all of the members that meet the SPA eligibility criteria through step 3 above and do not meet any of the specific program enrollment targeting and exclusionary criteria listed in step 4. The MCPs will use the TEL, their TEL verification process, and their internal priority

engagement rules to focus their enrollment activities and enroll the most appropriate members into HHP. The TEL Supplement will contain members that meet the SPA eligibility requirements for chronic condition criteria but are not included on the TEL. The TEL and the TEL Supplement will be provided within the same physical data set with the appropriate indicators.

TEL and TEL Supplement List Management

DHCS' expectations are that most of the HHP eligible members will be identified on the first TEL/TEL Supplement for an MCP in a region (first for chronic conditions, and six months later, for SMI) and most subsequent TEL/TEL Supplement files, at six month intervals, will have a smaller number of new members. To manage the members that appear on the TEL and the TEL Supplement, DHCS is considering the following parameters:

- Members may not appear on subsequent TEL/TEL Supplement files for an MCP because:
  - The member is no longer Medi-Cal eligible in MEDS
  - The member has changed MCPs
  - The member may not meet the disease identification or SPA eligibility requirements for chronic condition criteria
- Members may move from the TEL to the TEL Supplement and from the TEL Supplement to the TEL

TEL and SPA Assignment

DHCS is required to provide separate reporting to CMS for the HHP SMI SPA and the HHP Physical Health\SUD SPA. This requirement is reflected in the HHP implementation schedule. The TEL/TEL Supplement process includes all SPA-defined chronic conditions in the initial steps. In order to support the implementation schedule and MCP requests for additional TEL-related information, the initial TEL/TEL Supplement in each geographic implementation group will include both Physical health/SUD and SMI conditions.

However, members with only SMI conditions are not eligible for the first implementation in each County. The SMI-only members on the TEL/TEL Supplement are identified when Chronic Condition Criteria #3 equals '1' and Chronic Conditions Criteria #1, #2, and #4 are all equal to '0'. MCPs will be required to separately identify HHP members between physical health\SUD and SMI on the Supplemental Payment file sent to DHCS for payment purposes (See DHCS' *Technical Guidance – Consolidated Supplemental Upload Process* for further information).

HHP TEL/TEL Supplement – Fixed-width Record Layout v1.3

Field Id	Field Name	Description	Length	Start	End	Data Type
1	TEL Report Date	Date of generation of the TEL and TEL Supplement (CCYYMMDD)	8	1	8	A

Field Id	Field Name	Description	Length	Start	End	Data Type
2	CIN	Client Identification Number is the unique Member ID assigned by MEDS.	9	9	17	A
3	Birth Date	Member's Birth date (CCYYMMDD format).	8	18	25	A
4	Age	Member's Age	3	26	28	A
5	Member's Last Name	Member's Last Name	20	29	48	A
6	Member's First Name	Member's First Name.	20	49	68	A
7	Member's Middle Initial	Member's Middle Initial	1	69	69	A
8	Member's Gender Code	Member's Gender Code	1	70	70	A
9	Member's County Code	Member's County Code	2	71	72	A
10	Member's County Code Description	Member's County Code Description	15	73	87	A
11	Member's Primary Aid Code	Member's Primary Aid Code	2	88	89	A
12	Medicare Part A Status	Medicare Part A Status	1	90	90	A
13	Medicare Part B Status	Medicare Part B Status	1	91	91	A
14	Medicare Part D Status	Medicare Part D Status	1	92	92	A
15	Plan Code for Member	Plan Code for Member	3	93	95	A
16	Asthma Chronic Condition	Member met the HHP criteria for Asthma ('1' for yes, '0' for no).	1	96	96	A
17	Bipolar Chronic Condition	Member met the HHP criteria for Bipolar ('1' for yes, '0' for no).	1	97	97	A
18	Chronic Congestive Heart Failure (DHF) Chronic Condition	Member met the HHP criteria for Chronic Congestive Heart Failure ('1' for yes, '0' for no).	1	98	98	A
19	Chronic Kidney Disease Chronic Condition	Member met the HHP criteria for Chronic Kidney Disease ('1' for yes, '0' for no).	1	99	99	A
20	Chronic Liver Disease Chronic Condition	Member met the HHP criteria for Chronic Liver Disease ('1' for yes, '0' for no).	1	100	100	A

Field Id	Field Name	Description	Length	Start	End	Data Type
21	Coronary Artery Disease Chronic Condition	Member met the HHP criteria for Coronary Artery Disease ('1' for yes, '0' for no).	1	101	101	A
22	Chronic Obstructive Pulmonary Disease Chronic Condition	Member met the HHP criteria for Chronic Obstructive Pulmonary Disease ('1' for yes, '0' for no).	1	102	102	A
23	Dementia Chronic Condition	Member met the HHP criteria for Dementia ('1' for yes, '0' for no).	1	103	103	A
24	Diabetes Chronic Condition	Member met the HHP criteria for Diabetes ('1' for yes, '0' for no).	1	104	104	A
25	Hypertension Chronic Condition	Member met the HHP criteria for Hypertension ('1' for yes, '0' for no).	1	105	105	A
26	Major Depression Disorders Disease Category	Member met the HHP criteria for Major Depression Disorders ('1' for yes, '0' for no).	1	106	106	A
27	Psychotic Disorders Chronic Condition	Member met the HHP criteria for Psychotic Disorders ('1' for yes, '0' for no).	1	107	107	A
28	Filler	Filler	1	108	108	A
29	Traumatic Brain Injury Chronic Condition	Member met the HHP criteria for Traumatic Brain Injury ('1' for yes, '0' for no).	1	109	109	A
30	Filler	Filler	2	110	111	A
31	Chronic Condition Criteria #1	Member met the HHP Chronic Condition Criteria #1 (At least two of the following conditions: Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease (CKD), Diabetes, Traumatic Brain Injury, Chronic Congestive Heart Failure, Coronary Artery Disease, Chronic Liver Disease, Dementia, and Substance Use Disorder) ('1' for yes, '0' for no).	1	112	112	A

Field Id	Field Name	Description	Length	Start	End	Data Type
32	Chronic Condition Criteria #2	Member met the Chronic Condition Criteria #2 (Hypertension and at least one of the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease, or Chronic Congestive Heart Failure) ('1' for yes, '0' for no).	1	113	113	A
33	Chronic Condition Criteria #3	Member met Chronic Condition Criteria #3 (Any one of the following conditions: Major Depression Disorders, Bipolar Disorder, or Psychotic Disorders) ('1' for yes, '0' for no).	1	114	114	A
34	Chronic Condition Criteria #4	Member met Chronic Condition Criteria #4 (Asthma) ('1' for yes, '0' for no).	1	115	115	A
35	Count of Chronic Condition Criteria	A count of the number of Chronic Conditions Criteria the member met.	1	116	116	A
36	Acuity Factor #1	Member met acuity factor #1: three or more of the HHP eligible chronic conditions ('1' for yes, '0' for no).	1	117	117	A
37	Acuity Factor #2	Member met acuity factor #2: one or more inpatient stay ('1' for yes, '0' for no).	1	118	118	A
38	Acuity Factor #3	Member met acuity factor #3: three or more ED visits ('1' for yes, '0' for no).	1	119	119	A
39	Count of ED visits	The number of Emergency Department visits during the study period.	3	120	122	A
40	Latest ED visit DOS	The date of service for the most recent Emergency Department visit.	8	123	130	A
41	Count of Inpatient Admissions	The number of Inpatient Admissions during the study period.	3	131	133	A
42	Latest Inpatient Admission DOS	The date of service for the most recent Inpatient Admission.	8	134	141	A
43	Exclusion - Duals	The member is Dual Eligible ('1' for yes, '0' for no).	1	142	142	A
44	Exclusion - Hospice	The member had at least one service with one of the following revenue codes 0651, 0652, 0655, 0656, 0657, or with the following procedure code T2045 in the time period ('1' for yes, '0' for no).	1	143	143	A

Field Id	Field Name	Description	Length	Start	End	Data Type
45	Exclusion - ESRD	The member had at least one service with one of the following procedure codes in the time period, Z6004, Z6006, Z6012, Z6014, Z6016, Z6018, Z6022, Z6036, Z6038, Z6040, Z6030, 90967, 90968, 90969, 90970, 90989, 90993, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90935, 90937, 90945, 90947 ('1' for yes, '0' for no).	1	144	144	A
46	Exclusion - CCS	The member had at least one CCS End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	145	145	A
47	Exclusion - GHPP	The member had at least one GHPP End Date after the last month of the observation period or later ('1' for yes, '0' for no).	1	146	146	A
48	Exclusion - TCM	The member had at least one Targeted Case Management service in the time period (services where the Vendor Code was "92" or "93" ('1' for yes, '0' for no).	1	147	147	A
49	Exclusion - 1915c	The member met at least one of the following 1915c exclusions defined below, HIVAExcl, ALWExcl, DDExcl, IHOExcl, MSSPExcl, or PPC_Exclu ('1' for yes, '0' for no).	1	148	148	A
50	Exclusion - HIV/AIDS Waiver	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver exclusion. The member had at least one service in the time period where the Provider type was "073" and Procedure Code in (90837, 90846, 90847, 90847, G0156, G0299, G0300, S5130, S5165, S5170, S9470, T2003, T2022, T2025, T2026, T2028, T2029) ('1' for yes, '0' for no).	1	149	149	A
51	Exclusion - Assisted Living Waiver	Assisted Living Waiver (ALW) Exclusion. The member had at least one service in the time period where the Vendor Code In ("44" or "84"), and (Provider Type was "092", "093", or "014"), and (the Category of Service was 118 or 119) ('1' for yes, '0' for no).	1	150	150	A

Field Id	Field Name	Description	Length	Start	End	Data Type
52	Exclusion - Developmental Disabilities Waiver	HCBS Waiver for Californians with Developmental Disabilities (DD) exclusion. The member had at least one service in the time period where the Vendor Code was "76" and the Procedure Code in (Z9002, Z9003, Z9004, Z9005, Z9012, Z9014, Z9015, Z9016, Z9020, Z9021, Z9022, Z9023, Z9025, Z9025, Z9026, Z9026, Z9027, Z9028, Z9029, Z9030, Z9031, Z9032, Z9034, Z9038, Z9039, Z9043, Z9046, Z9047, Z9048, Z9050, Z9056, Z9058, Z9059, Z9060, Z9061, Z9062, Z9063, Z9064, Z9065, Z9066, Z9067, Z9069, Z9072, Z9073, Z9074, Z9075, Z9076, Z9077, Z9078, Z9079, Z9101, Z9102, Z9103, Z9104, Z9105, Z9106, Z9110, Z9111, Z9112, Z9113, Z9121, Z9122, Z9123, Z9124, Z9125, Z9126, Z9200, Z9202, Z9203, Z9204, Z9205, Z9206, Z9207, Z9208, Z9302, Z9303, Z9304, Z9305, Z9306, Z9307, Z9308, Z9310, Z9311, Z9312, Z9313, Z9314 ,Z9315, Z9400, Z9401, Z9402, Z9403, Z9404, Z9405, Z9406, Z9406, Z9407, Z9408, Z9999) ('1' for yes, '0' for no).	1	151	151	A
53	Exclusion - IHO/HCBA Waivers	In-Home Operations Waiver (IHO) / Home and Community-Based Alternatives (HCBA) exclusion. The member had at least one service in the time period where the Vendor Code was "71" and Provider type is “014, 059, 066, 067, 069, 078, 095”) or where the Vendor Code was "89" and the Special Program Code (SPECIAL_PGM_TYPE_CD was "3" (IHO Personal Care Services (WPCS)) ('1' for yes, '0' for no).	1	152	152	A

Field Id	Field Name	Description	Length	Start	End	Data Type
54	Exclusion - MSSP Waiver	Multipurpose Senior Services Program Waiver (MSSP) exclusion. The member had at least one service in the time period where the Vendor Code was "81", the Provider Type is '074', and the Procedure Code in (Z8550, Z8551, Z8552, Z8553, Z8554, Z8555, Z8556, Z8557, Z8558, Z8559, Z8560, Z8561, Z8562, Z8563, Z8564, Z8565, Z8566, Z8567, Z8568, Z8569, Z8570, Z8571, Z8572, Z8573, Z8574, Z8575, Z8576, Z8580, Z8581, Z8582, Z8583, Z8584, Z8585, Z8586, Z8587, Z8588, Z8589, Z8590, Z8591, Z8592, Z8593, Z8594, Z8595, Z8596, Z8597, Z8598, Z8599, Z8600, Z8601, Z8602, Z8603) ('1' for yes, '0' for no).	1	153	153	A
55	Exclusion - PPC Waiver	Pediatric Palliative Care (PPC) Waiver exclusion. During the observation period, the member in one of the following counties: Fresno, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, Sonoma, or Ventura, the Provider Type is '014 or '039, the Category of Service is '120, and the Procedure Code is 'G9012' ('1' for yes, '0' for no).	1	154	154	A
56	Exclusion - PACE, SCAN, AHF	PACE, SCAN, and AHF exclusion. As of the last month, the member had one of the following Plan Codes: 050-065, 200-207, 601, or 915. ('1' for yes, '0' for no).	1	155	155	A
57	Exclusion - LTC Resident	Long Term Nursing Facility residents exclusion. As of the end of the study period the member had one of the following Long Term Care (Nursing Facility) Aid Codes: "13", "23", "53", or "63" ('1' for yes, '0' for no).	1	156	156	A
58	Exclusion - FFS	Fee-For-Service exclusion. As of the end of the study period the member was in Fee For Service (Plan Code 000) ('1' for yes, '0' for no).	1	157	157	A
59	Count of Exclusions	A count of the number of Exclusions for which the member met the requirements.	2	158	159	A
60	TEL Indicator	A value of "1" indicates a TEL record; a value of "0" indicates a TEL Supplement record	1	160	160	A

C. Appendix C – Training Requirements

This section outlines training that MCP and CB-CME staff who will be delivering HHP services are required to receive prior to participating in the administration of the HHP. It also includes recommendations for training CB-CME staff on several core competencies.

Required HHP Trainings for Prior to HHP Implementation
MCP and CB-CME staff who will be delivering HHP services are required to receive HHP-specific training prior to HHP implementation. The required training topics described below cover basic program components. DHCS provided PowerPoint training materials that MCPs can leverage for their required trainings. However, it is also acceptable for an MCP to use non-DHCS developed training materials to satisfy one, or more, of the requirements. DHCS-developed training materials are saved on both the portal and DHCS' Health Homes Program website.

MCPs must be prepared to follow the required high-level trainings with more specific HHP operational training for their staff and CB-CME staff that provide HHP services. This should include MCP-specific information on operations, workflows, how HHP intersects with MCP care coordination initiatives, data reporting, and other implementation issues. DHCS and Harbage Consulting will work with each MCP to discuss their needs and the best approach for providing the required trainings.

The required HHP training topics are:

1. **Health Homes Program Overview**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on the program. Required training modules shall describe the goals and scope of the HHP, team member roles and how they should work together, the services that should be provided, and how HHP intersects with other California state care coordination programs. The training shall introduce topics related to caring for the populations served under HHP, including those with chronic conditions and homeless individuals, and the impact of social determinants of health on patients.

2. **Health Action Plan, Care Coordination, and Care Transitions within the Health Homes Program**

All MCP and CB-CME staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan, conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.

3. **Community Resources and Referrals** (required for care coordinators and housing navigators)

This training shall provide information about available community resources, how to develop relationships with community partners, and best practices for connecting members to community services. This training is required for MCP and CB-CME care coordinators and housing navigators.

MCPs are encouraged to provide additional training and/or guidance about specific local and community organizations and resources available to the CB-CME staff.

Recommended but Optional Training for CB-CME Staff on Core Competencies

DHCS recommends that relevant MCP and CB-CME staff receive training on the following core competencies in order to successfully implement HHP. DHCS plans to provide trainings and/or resources on these topics, which will be saved on the portal and available on-demand.

1) Special Populations (homelessness, domestic violence, SMI, etc.)

Team members should have access to training and resources specific to the patient populations they serve.

2) Social Determinants of Health

Trainings and resources related to social determinants of health should be made available for team members. Social determinants of health include gender, age, education, income and employment, social/cultural networks, housing and physical environments and other factors that impact health outcomes and access to care.

3) Motivational Interviewing

Motivational interviewing is a communication technique that seeks to elicit an individual's internal motivation to make set and accomplish positive goals. The technique uses a non-confrontational, collaborative approach to help the patient find his or her own motivation and initiate change. The patient is empowered to make personal choices, resulting in increased likelihood of compliance with care plans.

4) Trauma-informed Care

Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma. Trauma-informed care emphasizes safety (physical, psychological and emotional) for patients and providers and seeks to empower patients with self-care tools.

5) Health Literacy Assessment

Health literacy refers to a patient's capacity to find and understand health information and services in order to make informed health decisions. Assessment of patient health literacy is essential to the creation of a patient-centered care plan.

6) Information Sharing

Team members should be trained on requirements related to sharing member information and data with other entities for the purpose of care coordination. These entities include the MCP, CB-CMEs, the care team, the county, hospitals, other providers, and community-based organizations including housing organizations.

D. Appendix D – Readiness Requirements and Checklist

Readiness Requirements and Checklist

This checklist is not intended to be all-inclusive. Additional information as needed may be requested by the Department.

General Instructions

Thank you for your interest in participating in the Health Homes Program (HHP). To ensure that Medi-Cal managed care health plans (MCPs) are ready to implement the Health Homes Program, MCPs must submit the documentation listed below and attest that other program requirements have been completed. **There are multiple deadlines for submissions for each implementing MCP group. Please see Appendix I for the HHP Implementation Schedule by group. Submission deadlines for each group are as follows:**

1. **Group 1 – March 1, 2018; May 1, 2018; and November 1, 2018.**
2. **Group 2 – September 1, 2018; November 1, 2018; February 1, 2019; and May 1, 2019.**
3. **Group 3.1 – January 1, 2019; April 1, 2019; July 1, 2019; and October 1, 2019.**
4. **Group 3.2 – March 1, 2019; May 1, 2019; August 1, 2019; and November 1, 2019.**
5. **Group 4 – September 1, 2019; November 1, 2019; February 1, 2020; and May 1, 2020.**

List of Deliverables:

Policies and Procedures (P&Ps) and Attestations: Section I – HHP Infrastructure (Deliverables #1 – 3), Section II – HHP Services (Deliverables #4 – 5), Section IV – General HHP Operations (Deliverables #7 – 10 and 12), and the Attestations (Deliverable #13)

Network: Section III – Network (Deliverable #6.1, 6.3, 6.4, 6.5)

SMI– MHP-MOU: Section IV – General HHP Operations, MHP-MOU (Deliverable #11.1)

SMI Network: Section III – Network (Deliverables #6.2a and 6.2b)

Group	Counties	Deliverable Due Dates		Deliverable Approval Dates
Group 1	San Francisco	**P&Ps**:	3/1/18	5/1/18
		Network:	5/1/18	6/1/18
		SMI Deliverables:	11/1/18	12/1/18
Group 2	Riverside San Bernardino	**P&Ps**:	9/1/18	11/1/18
		Network:	11/1/18	12/1/18
		SMI MHP-MOU:	2/1/19	3/1/19
		SMI Network:	5/1/19	6/1/19
Group 3.1	Imperial Santa Clara	**P&Ps**:	1/1/19	5/1/19
		Network:	4/1/19	6/1/19
		SMI MHP-MOU:	7/1/19	8/1/19
		SMI Network:	10/1/19	12/1/19
Group 3.2	Alameda Kern Los Angeles Sacramento San Diego Tulare	**P&Ps**:	3/1/19	5/1/19
		Network:	5/1/19	6/1/19
		SMI MHP-MOU:	8/1/19	9/1/19
		SMI Network:	11/1/19	12/1/19
Group 4	Orange	**P&Ps**:	9/1/19	11/1/19
		Network:	11/1/19	12/1/19
		SMI MHP-MOU:	2/1/20	3/1/20
		SMI Network:	5/1/20	6/1/20

DHCS expects the deliverables to be submitted in the form of MCP policies and procedures except for the organizational chart, assessment tool, health action plan template, network adequacy tables, and CB-CME subcontract. MCPs may develop standalone policies and procedures for the HHP and/or may incorporate HHP into existing policies and procedures.

MCPs are to submit a separate set of deliverables for each county they are implementing HHP in. If one or several deliverables cover multiple counties, MCPs are not required to submit the deliverable for each county. However, the MCP must indicate which counties the deliverable applies to during the submission process. The network tables that MCPs submit are to be separated by county.

For MCPs in multiple groups, the plan should not resubmit deliverables already approved for a prior group, unless changes have been made.

When submitting existing policies & procedures with HHP-related revisions, please use the "track changes" function in Word, or strike-thru/underline equivalent in other applications, to show deletions and additions. Other forms of documentation are also permitted to supplement MCP policies and procedures. If single documents are used to demonstrate compliance with multiple requirements/deliverables, please provide a crosswalk with the specific location for each deliverable.

Please see the *"Medi-Cal Health Homes Program: Program Guide"* (Program *Guide)* for Health Home Program requirements that correspond to this Readiness Checklist.

Submission Requirements

MCPs should follow the regular process for submitting required deliverables to their current Contract manager(s). Please submit HHP-related deliverables to 2PlanDeliverables@dhcs.ca.gov and copy the HHP mailbox at hhp@dhcs.ca.gov.

For each submission, please provide the Plan's Name and the primary Contact Person's name and telephone number.

In addition, when submitting, please use the following email subject line and file naming conventions:

- In the subject line of the email, please note that these are HHP Deliverables by using the following subject line convention:
  "HHP Deliverable 1"; "HHP Deliverables 2 and 3"; etc.

- Please use the following file naming convention:
  [plan name and deliverable number]

The Contact Person is responsible for ensuring that all documentation and attestations are accurate. Questions may be directed to hhp@dhcs.ca.gov. DHCS will provide additional information as it becomes available, and may request additional information at a later date.

I. HHP Infrastructure

1. Organizational Model:

1.1 Submit MCP's policies and procedures describing the HHP infrastructure, the roles and division of labor between the MCP and Community-Based Care Management Entities (CB-CMEs), and whether the MCP delegates any responsibilities to other entities.

1.2 Organizational chart illustrating the HHP infrastructure.

2. Staffing:

2.1 Submit MCP's policies and procedures describing the staffing plan for MCP and CB-CMEs, including care coordinators, community health workers, and housing navigator(s). The care coordinator ratio requirements are included in the Program Guide; however, if an MCP is interested in using a staffing model that de-emphasizes the care coordinator and instead emphasizes the roles of other team members, please describe the model here and DHCS will consider how to handle the care coordinator ratio.

The participation of community health workers in appropriate roles is recommended but not required.

2.2 Job descriptions for care coordination staff, including MCP and CB-CME staff, as appropriate.

3. Health Information Technology/Data and Information Sharing:

3.1 Submit MCP's policies and procedures describing how information is shared among the entire care team (including the member, CB-CME, and MCP), including whether EHR/HIT/HIE, or other methods, are used regarding the following activities:

a. Comprehensive Care Management
   - Identify cohort and integrate risk stratification information.
   - Shared care plan management – standard format.
   - Clinical decision support tools to ensure appropriate care is delivered.
   - Electronic capture of clinical quality measures to support quality improvement. Include other methods if electronic means of collection are not used.

b. Care Coordination and Health Promotion
   - Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
   - Tools to support shared decision-making approaches with patients.
   - Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.
   - Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.
   - Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.
   - Telehealth services including remote patient monitoring.

c. Comprehensive Transitional Care
   - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER. Include other methods if an electronic process is not used.

- Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR. Include other methods if electronic sharing is not used.
- Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

d. Individual and Family Support Services
   - Patient specific education resources tailored to specific conditions and needs.

e. Referral to Community and Social Support Services
   - Electronic capture of social, psychological and behavioral data (e.g. education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.
   - Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used.

II. HHP Services

4. Care Management:

5.1 Submit the assessment template or tool reflective of HHP-required elements such as housing instability, palliative care, and trauma-informed care.

5.2 Submit the Health Action Plan (HAP) template.

5.3 Submit MCP's policies and procedures for conducting care management, including how the MCP, in conjunction with contracted CB-CME, will:
- Develop and implement an HHP member assessment and HAP requirements and process, with enrollee and caregiver participation;
- Design the multi-disciplinary care team composition and process;
- Manage the communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; and
- Maintain an HHP call line or have another mechanism for responding to enrollee inquiries and input related to HHP. The MCP's member service call center or 24/7 nurse line may satisfy this requirement; however, the MCP or CB-CME may also utilize a local on-call service knowledgeable about the HHP.
- Maintain a process for referring to other agencies, such as long term services and supports (LTSS) or behavioral health agencies, as appropriate.
- Disenroll members from HHP who no longer qualify for or require HHP services.

5. Care Transitions:

5.1 Submit MCP's policies and procedures for conducting care transitions, including discharge-planning workflows.

III. HHP Network

6. MCP Duties/Responsibilities - Health Homes Program Network

6.1 Physical Conditions and SUD implementation

Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected enrollment and capacity as of the program launch date and as of the last day of each quarter in the first year for the Physical Chronic Conditions/SUD implementation. "Projected capacity" is the maximum caseload of the MCP's Physical Chronic Conditions/SUD HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of Physical Chronic Conditions/SUD HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable is due as a part of the Network Deliverables submission.

Please provide expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – Physical Conditions and SUD**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

Note: A separate DMHC network review specific to HHP will not be conducted; however, DMHC will continue to conduct regular Knox-Keene Act required network reviews through DMHC established processes.

6.2 SMI Implementation

a. Provide a list of CB-CMEs expected to be contracted, their NPI numbers, and their expected contract effective dates. For each CB-CME, provide the projected HHP enrollment and capacity for these CB-CMEs as of the program launch date and as of the last day of each quarter in the first year for the SMI implementation. "Projected capacity" is the maximum caseload of the MCP's SMI HHP enrollees for the county in question that the MCP estimates a CB-CME is able to manage. Plans should be mindful of HHP care manager ratio requirements and any additional certification requirements they imposed on their CB-CMEs when determining this estimate. "Projected enrollment" is the number of SMI HHP members the MCP realistically estimates will be enrolled into HHP for each time period. Plans should take into account the number of members on the TEL, the estimated engagement rate of potential members, and the assumptions about member enrollment included in the HHP rate package. DHCS expects MCPs to demonstrate expanding capacity over time that corresponds with planned enrollment expansion. Please only include CB-CMEs that will have primary responsibility for care coordination services. List the MCP if the MCP is also expected to serve in the CB-CME role. This deliverable update is due as a part of the SMI Deliverables submission.

Please provide the expected network capacity and enrollment information for each time period using the following table format. MCP is required to submit separate network tables for each county, as applicable.

Plan:		**CB-CME Network Enrollment and Capacity Table – SMI**								**County:**		
CB-CME Name	**CB-CME NPI #**	**Estimates by CB-CME**										**Expected Contract Effective Date**
		(Launch Date) Estimated HHP:		**(Last Day of Q1) Estimated HHP:**		**(Last Day of Q2) Estimated HHP:**		**(Last Day of Q3) Estimated HHP:**		**(Last Day of Q4) Estimated HHP:**		
		Enrollment	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	**Enrollment**	**Capacity**	

If, after network submission and approval but prior to the program launch date, the projected number of CB-CMEs and/or their enrollment capacity decreases below the approved network capacity, the MCP must notify DHCS in writing and provide a revised network table through the HHP@dhcs.ca.gov mailbox. If the change(s) reduces the network capacity below estimated enrollment amounts per quarter, the MCP must additionally provide an action plan for meeting estimated enrollment capacity by the program launch date.

b. Provide a description of how behavioral health providers are incorporated into the HHP service delivery model. This deliverable is due as a part of the SMI Deliverables submission.

6.3 If applicable, provide any MCP-specific CB-CME qualifications (beyond the CB-CME qualifications listed in section V.B, CB-CME Qualifications) that the MCP requires for the CB-CME to contract for HHP Services. This deliverable is due as a part of the Network Deliverables submission.

6.4 Submit CB-CME oversight policies and procedures, including monitoring, corrective action, progressive consequences for continued non-compliance, auditing care coordination conducted by CB-CMEs. This deliverable is due as part of the Network Deliverables Submission.

6.5 Submit CB-CME subcontract boilerplate that complies with the DHCS MCP contract requirements and includes: 1) Business Associate Agreement that allows for information and data sharing between MCP and CB-CME, 2) CB-CME to provide services in accordance with requirements in this Program Guide, and 3) CB-CME to complete DHCS/MCP required training. **If submitting prior DHCS approved subcontract boilerplate with HHP-related revisions, please use the "track changes" function in Word, or the "strike-through/underline" equivalent in other applications, to show deletions and additions.** This deliverable is due as part of the Network Deliverables Submission.

Note: MCP must have DHCS-approved subcontracts or subcontract amendments with a sufficient number of CB-CMEs to serve its HHP enrollees.

IV. General HHP Operations

7. Non-Duplication of Care Coordination Services:

7.1 Submit MCP's policies and procedures for ensuring that members are not enrolled in another Medi-Cal care coordination program that would disqualify them from receiving HHP services (see Program Guide for requirements).

8/9. HHP Outreach Requirements

8.1 Member Engagement:

Submit MCP's policies and procedures that include the following:

- Protocols for a progressive outreach campaign (see Program Guide Appendix A for model outreach campaign protocols)
- Process for assisting members who require additional prompting or guidance to participate;
- Process for conducting outreach to homeless individuals;
- Process for reviewing and excluding names from the Targeted Engagement List (TEL), including the MCP's definition of "well managed" (based on DHCS guidelines

of having no substantial avoidable utilization **or** enrollment in another acceptable care management program – see Reporting Template-Instructions for definition);

- After people have been excluded from the TEL based on the process above, the process and criteria for identifying a "priority engagement group" or ranking process within the remaining TEL members. This group, or members in order or priority rank, would be the first focus for MCP engagement efforts. The criteria and size of the group for 'priority engagement' status will be at the MCP's discretion (upon approval by DHCS) with the goal of engaging and serving TEL members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

9.1 Member Notices:

All beneficiary notices to be sent by the MCP regarding the HHP should be filed for DHCS review. If the MCP is licensed by DMHC, these notices should additionally be filed with DMHC for review. DHCS is aligning with DMHC requirements regarding notice review, and DMHC requires MCPs to file all advertisements for review. All outreach materials and scripts that will be distributed should be filed prior to use by the MCP. Submission through this readiness checklist process will begin the DHCS notice review/approval process. MCPs may provide notices for DHCS review at any time prior to the member notices deliverable due date.

Note: Notices must conform to all of the usual requirements for Medi-Cal member notices, including reading level. DHCS' HHP Beneficiary Toolkit is an optional resource for the MCPs for examples of 'best practice' member messaging (though the HHP Member Toolkit messaging may need to be adjusted to comply with Medi-Cal and DMHC member notice requirements). All members must be informed 30 days prior to implementation of this new Medi-Cal covered benefit. An update to the Evidence of Coverage/Disclosure Form is required; however, plans may provide an HHP-specific errata to satisfy this EOC requirement. DHCS provides a template for Evidence of Coverage/Disclosure Form HHP language in Appendix F.

10. Risk Grouping:

10.1 Submit MCP's policies and procedures for ensuring that HHP members receive the appropriate services at the appropriate intensity level, including tiering of services based on risk grouping and the associated payment structure (but not amounts). See Section V. Health Homes Program Network, G. Risk Grouping in this Program Guide for additional information.

11. Mental Health Services:

11.1 Signed local Mental Health Plan (MHP) Health Memorandum of Understanding (MHP-MOU) to ensure seamless access and delivery of mental health services. The MHP-MOU must be in place as of the date of implementation of HHP for members

with SMI conditions. MCPs will develop or amend existing MOUs with county MHPs to address HHP-specific information.

DHCS has released All Plan Letter (APL) 18-015 (which supersedes APL 13-018), including Attachment 2 of this APL, to address the HHP-specific information that MCPs must include in new, or amended, MOUs. MCP must submit the new or amended MHP-MOU by November 1, 2018 for Group 1 MCPs; February 1, 2019, for Group 2 MCPs; July 1, 2019 for Group 3.1 MCPs; and August 1, 2019 for Group 3.2 MCPs.

12. Housing Services:

12.1 Submit MCP's policies and procedures for providing the required housing services, including how the MCP will identify and work with community resources to ensure seamless access to delivery of housing support services. MCPs must provide housing navigation services, not just referrals to housing. (See Program Guide for requirements.)

13. Health Homes Program Readiness – Attestations

The operational process attestations below reflect the MCP's commitment to being fully prepared as of the HHP implementation date. Please check the boxes and sign below to indicate MCP's compliance with the following readiness requirements for the Health Homes Program.

☐ **F. Training**: Attest (check the box) that the MCP and CB-CMEs will complete all DHCS-required HHP training prior to participating in the administration of the HHP, as outlined in the *Program Guide*.

☐ **G. Service Directory**: Attest (check the box) that the MCP or the CB-CME(s) has completed and will maintain a directory of community services and supports that is available to all CB-CMEs and care coordinators.

☐ **H. Quality of Care**: Attest (check the box) that the MCP has incorporated HHP into existing quality management processes.

☐ **I. Cultural Competency, Educational and Health Literacy**: Attest (check the box) that the MCP has incorporated HHP into existing Policies & Procedures on these topics.

☐ **J. Member Communication**: Attest (check the box) that the MCP has incorporated HHP into existing policies regarding communicating with members, including: using secure email, web portals or written correspondence to communicate; and taking enrollee's individual needs (communication, cognitive, or other barriers), into account in communicating with enrollee.

☐ **K. Members Experiencing Homelessness**: Attest (check the box) that the MCP has incorporated HHP-specific information into the appropriate Policies & Procedures for homeless members, including special service requirements, provider criteria (to comply with homeless experience requirements per AB 361), and engagement processes.

☐ **L. Reporting**: Attest (check the box) that the MCP has the capability to track HHP enrollee activity and report on outcomes, as required by DHCS, including HHP service encounters for services provided by the MCP and the CB-CMEs (see *Program Guide* and *reporting template* for reporting requirements).

☐ **M. Service Requirements**: Attest (check the box) that the MCP will comply with all the with all service requirements, including for the six core services and the additional service requirements listed in the Program Guide.

I am authorized to make this attestation on behalf of:

_____	_____
Managed Care Plan	Signature of Authorized Representative
_____	_____
Date	Name of Authorized Representative
	_____
	Title of Authorized Representative

E. Appendix E – Service Codes for the Health Homes Program

DHCS has defined the ACA 2703 Health Home Program (HHP) service codes for use on encounters and for other purposes. The HHP is required to utilize HIPAA-compliant coding standards. This revised coding scheme incorporates comments received on the initial proposed coding scheme released in October 2016. The HHP team and the DHCS Office of HIPAA Compliance identified CPT and HCPCS codes for HHP. In addition, the HHP team investigated other potential codes and reviewed codes used by a few other states.

DHCS initially selected HCPCS code G0506 for HHP, however it was found to conflict with National Correct Coding Initiative rules. DHCS instead adopted HCPCS code G9008 effective as of 10/1/2018. The definition of G9008 is as follows: Coordinated care fee, physician coordinated care oversight services. G9008 along with seven different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	**HCPCS Code**	**Modifier**	**Units of Service (UOS)**
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Telehealth and Group Visits

Regarding the use of the HHP HCPCS code and modifiers for HHP services provided via Telehealth and group visits – specifically, if MCPs may submit HHP encounters for telehealth and group visits using the HHP HCPCS code and modifiers for HHP in-person visits and if they may be used to satisfy the in-person visit ratio requirement – DHCS offers the following clarifying guidance.

Telehealth visits generally may not be used to meet the in-person visit ratio requirement for HHP. However, on a case by case basis, if an MCP has certain circumstances that necessitate the use of a high volume of telehealth visits for HHP, and the MCP is unable to meet the HHP in-person visit requirement because of the high-volume use of telehealth, DHCS will evaluate the circumstances and may allow the MCP to utilize some telehealth visits to meet the in-person visit requirement.

DHCS expects that group visits to be primarily used for health promotion and educational purposes as opposed to one-on-one HHP care coordination. However, if there is a one-on-one in-person component to the group visit in which the provision of any of the six core HHP services are provided, this may be reported as a separate HHP in-person visit encounter.

F. Appendix F – Evidence of Coverage Template

Description:

<Plan Name> covers Health Homes Program (HHP) services for Members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for Members with chronic conditions.

You may be contacted if you qualify for the program. You can also call <Plan Name>, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call <Plan Name> to find out the conditions that qualify; and
- You meet one of the following:
  - You have three or more of the HHP eligible chronic conditions
  - You stayed in the hospital in the last year
  - You visited the emergency department three or more times in the last year; or
  - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP Services:

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers, and others, to coordinate your care. <Plan Name> provides HHP services, which include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Cost to Member:

There is no cost to the Member for HHP services.

G. Appendix G – Reporting Template Excerpt

The below is an excerpt from the complete Reporting Template that MCPs will use to submit specific required data. For descriptions of data elements, please see Reporting Template.

Note: CPB = Controlling High Blood Pressure; CDF = Screening for Clinical Depression and Follow-up Plan; SMI = Serious Mental Illness/Serious Emotional Disturbance.

Health Home Program (HHP) Reporting Instructions

These instructions outline the requirements, references, and headings/categories for the following reporting template: Health Home Program Reporting Template. Reporting is required per the managed care contract.

• Data must be submitted in Excel (.xlsx). Do not submit data in .pdf, .xls, .csv, .txt, or any other format than .xlsx.

• The three months of data must be combined into one figure to represent the quarter, with the exception of member level Homeless and Housing reports and annual reports.

• Each MCP must submit only one file per reporting period that includes all counties the MCP operates in. All subcontractors must be rolled up into the main MCP's data.

• MCPs will certify the HHPQuarterlyReports or data submissions using the existing monthly data certification process with its respective DHCS Contract Manager to confirm all information submitted is complete and accurate. MCP will maintain documentation supporting the reported information.

Quarterly reports are due 60 days after the end of the quarter. Annual reports are due with Q1 reports. Member-level detail Homeless/Housing reports are due semi-annually, with the Q2 and Q4 reports. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date. For reference, the calendar-year quarters are listed below:

• Q1 and Annual – January, February, and March - due May 31

• Q2 and Member-level Homeless/Housing – April, May, and June - due August 31

• Q3 – July, August, and September - due November 30

• Q4 and Member-level Homeless/Housing – October, November, and December - due February 28

Unless otherwise noted, all "days" are calendar days.

Reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). Reports must use the following file naming convention: MCP name.HHPQuarterlyReport.Year.Quarter.DueDate.xlsx

[MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.xlsx.]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181130.xls. DHCS will not acknowledge or accept any email submissions.

All report revisions are subject to DHCS review and approval.

• DHCS will notify MCPs if revised reports must be submitted to correct data errors such as incorrect file naming conventions, incomplete data/columns fields, incorrect data, etc.

• Revised reports must be submitted to your designated folder in the "DHCS-MCQMD-Data\MCP\Monitoring\" subfolder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov).

• Revised reports must be submitted as a complete quarterly file. Partial files without all the required information and data will be rejected and must be resubmitted. Each quarter of data must be submitted separately. MCP must include an explanation in the HHP comments tab describing the changes and the reason for revision.

• Revised reports must use the following file naming convention: MCPName.HHPQuarterlyReport.Year.QuarterNumber.DueDate.RevisionNumber.xlsx [MCPName.HHPQuarterlyReport.YYYY.QTR#.YYYYMMDD.REV#.xlsx]. For example: MCPName.HHPQuarterlyReport.2018.QTR3.20181230.REV1.xlsx. to your designated folder in the "DHCS-MCQMD-Data/MCP" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov). The revised file should be submitted as a separate file.

• Final corrections to quarterly reports must occur no later than 90 days after the end of the calendar year for corrections on the previous year's quarterly reports unless the Department requests a revised file.

Definitions:

CB-CME: Community Based Care Management Entity

HAP: Health Action Plan

Homeless and Chronically Homeless: see CA Welfare & Institution Code § 14127(e)

Housing Services:
https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf - see "Individual Housing Transition Services" and "Individual Housing & Tenancy Sustaining Services" on pages 3-4.

For the purposes of this document, the following definitions will apply:

- **HHP Member**: a Medi-Cal beneficiary currently enrolled in a Medi-Cal Managed Care Plan and a Health Homes Program.

- **Member**: a Medi-Cal Managed Care Plan member not currently enrolled in a Health Homes Program.

- **Individual**: Medi-Cal beneficiary or other eligible person who may not be currently enrolled in a Medi-Cal Managed Care Plan or a Health Homes Program. E.g., FFS beneficiary. May also apply to person not currently enrolled in Medi-Cal.

Definitions of Exclusionary Reasons for Non-Enrollment: The following are the allowable reasons, with definitions, for which a Medi-Cal member may be excluded from, or not enrolled into, a local Health Homes Program (HHP). These definitions are used by DHCS and its HHP partners. For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage. See the definition of Targeted Engagement Process below for additional information.

I. ***Unsafe Environment***: for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ED: After reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment or deliver HHP services, such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff.

Individual: Member engagement/enrollment efforts, or delivery of HHP services, cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

II. ***Declined participation***: After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate in HHP.

III. ***Unsuccessful engagement***: HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self-available, or is un-cooperative. Accurate contact information is not available for the member. This occurs before enrollment.

IV. ***Well-managed***: An assessment, which may include a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.

V. ***Participation in duplicative programs or programs excluded for HHP participation due to DHCS policy***: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following:

1. Duplicative Programs

a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH)

b. Targeted Case Management (TCM) – County, not Mental Health TCM

c. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF)

2. Programs excluded by DHCS Policy

a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month.

b. Hospice

c. Fee-For-Service

VI. ***Targeted Engagement Process***: The MCPs DHCS-approved process by which MCPs identify and prioritize individuals for engagement by using DHCS-provided Targeted Engagement List (TEL) and/or MCP member data.

For the purpose of reporting the HHP Enrollment Reporting, Member Exclusions, MCPs are expected to report on individuals that the MCP actively seeks to engage, that is a result of the above mentioned DHCS-approved process.

1. Health Home Program Enrollment Reporting	
***Note:* Only report one (1) exclusionary reason per member excluded from the Program.**	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number MCP excluded because not eligible - well-managed (Column C)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because not eligible due to MCP assessment determining well managed. The CB-CME and/or the MCP can further define, but well-managed means (a) members with HHP chronic conditions that do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation; or (b) members that are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, determines that the member's eligible chronic conditions are already well managed – to the extent that HHP services are not medically necessary and will not significantly change the member's health status. This includes participation in other programs that are not Medicaid funded that may be available and for which the member is eligible.
Number MCP excluded because declined to participate (Column D)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because they declined to participate. After reasonable efforts have been made to explain the program and achieve engagement, the member declines to participate, or to continue to participate, in HHP.
Number MCP excluded because of unsuccessful engagement (Column E)	Enter the number of members MCP excluded via the targeted engagement process the quarter because of unsuccessful engagement. HHP staff is unable to engage the member after the MCP or the HHP provider has completed the requirements specified in the MCP's DHCS-approved policy for progressive engagement activities. The member does not engage, participate, or make self available; is un-cooperative; or accurate contact information is not available for the member. This occurs before enrollment.

Number MCP excluded because duplicative program (Column F)	Enter the number of members MCP excluded via the targeted engagement process during the quarter due to being in another program that provides care management services: DHCS or the MCP has developed new information that the member participates in, or is enrolled in, a Medicaid-funded program that provides services duplicative to HHP services or a program excluded by DHCS policy, and the member chooses to remain in the duplicative or excluded program. Duplicative Medicaid-funded programs include, but may not be limited to, the following: 1. Duplicative Programs a. 1915c waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH) b. Targeted Case Management (TCM) – County, not Mental Health TCM 2. Programs excluded by DHCS Policy a. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month. b. Hospice 3. Additional programs the MCP determines are duplicative as described in their progressive engagement policy
Number MCP excluded because unsafe behavior or environment (Column G)	Enter the number of members MCP excluded via the targeted engagement process during the quarter because of an unsafe behavior or environment. Unsafe includes Environment (for delivery of services outside of a regular healthcare facility such as a clinic, provider's office or ER): after reasonable efforts to arrange a different method or venue to conduct member engagement/enrollment such activities cannot be conducted without staff entering an environment that poses a significant risk to the physical or mental well-being of the staff; and Individual: Member engagement/enrollment efforts cannot be conducted due to the member's behavior posing a significant physical or mental threat to the well-being of the staff.

Number MCP excluded because not enrolled in Medi-Cal at MCP (Column H)	Enter the number of individuals MCP excluded from via the targeted engagement process list during the quarter because they are not enrolled in Medi-Cal at the Managed Care Plan. Reasons can include, but may not be limited to, the following: a. Fee-For-Service b. Specialty Managed Care Plans: Senior Care Action Network (SCAN), Program of All-Inclusive Care for the Elderly (PACE), AIDS Healthcare Foundation (AHF) c. Member is deceased
Number externally referred & enrolled (Column I)	Enter the number of members not part of the plan's targeted engagement process, referred to the MCP, that were enrolled. The referral process is initiated by an external provider or organization when an individual is initially assessed to be a candidate for HHP and therefore is referred to the MCP for approval. Upon MCP review and evaluation, if the individual is approved for HHP and enrolled, they would be included in this measure. If they are not approved for enrollment in HHP, they would be reported in the following measure.
Number externally referred but excluded (Column J)	Enter the number of individuals not part of the plan's targeted engagement process, referred to the MCP, that were excluded. Exclusion reasons include reasons identified in columns C-H. Do not add these exclusions to the counts in Columns C-H.
Average monthly number of dedicated care coordination FTEs (Column K)	Enter the average monthly number of care coordinators for the quarter. Only count FTEs dedicated to care coordination activities. The counts are taken at a point in time, which will be the last day of each month in the quarter, and averaged across the 3 months in the quarter to get this average quarterly number.
2. Health Home Program Member Activity Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.

Number initial HAP completed within 90 days (Column C)	Numerator: Enter the number of HHP members that had their initial HAP completed during the quarter and the HAP was completed within 90 days of enrollment.
Number initial HAP completed (Column D)	Denominator: Enter the number of HHP members that had their initial HAP completed during the quarter.

3. Health Home Program Homeless/Housing Member Level Detail	
Note: This tab is to be submitted semi-annually in the Q2 report and Q4 report of every year. The Q2 report (due 8/31) will include data for January through June of the current calendar year. The Q4 Report (due 2/28) will include data for July through December of the previous calendar year.	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for the county and plan code the plan operates in. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and semi-annual reporting period. For example, the second reporting period of 2019 will be entered as 2019 Q3-Q4.
Member CIN (Column C)	Enter the Member's Client Identification Number (CIN) for all members that meet Column G and/or Column I.
Member Last Name (Column D)	Enter the Member's Last Name.
Member First Name (Column E)	Enter the Member's First Name.
Member Date of Birth (DOB) (Column F)	Enter the Member's Date of Birth (DOB) using format MM/DD/YYYY.
Homeless HHP Members and HHP Members at Risk for Homelessness During This Reporting Period (Column G)	Indicate whether the HHP enrolled member met the Federal definition of Homeless or required tenancy sustaining services at any point during the reporting period. Enter "Yes" or "No."
Received Housing Services During This Reporting Period (Column H)	Indicate whether the HHP enrolled member received housing services at any point during the reporting period. Enter "Yes" or "No."
Homeless Health Homes Members In Any Enrollment Period (Column I)	Indicate whether the HHP enrolled member met the Federal definition of Homeless at any point during their enrollment in the HHP. Enter "Yes" or "No."

HHP Members who are no longer Homeless On Last Day of This Reporting Period (Column J)	Indicate the HHP enrolled member no longer meets the Federal definition of Homeless, as of the last day of the reporting period. If the member was disenrolled during the reporting period, report as of their last date of enrollment. Enter "Yes" or "No."
4. Health Home Program Network Reporting	
Column Name	**Explanation**
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year and quarter for the data reported: Year QX. For example, the 3rd quarter of 2018 will be entered as 2018 Q3.
CB-CME NPI # (Column C)	Enter all CB-CME NPI numbers that were contracted as of the last day of the quarter. Enter each CB-CME NPI number in each county on its own row. For example, if a MCP is contracted with a CB-CME that operates in two counties, there would be two rows for that NPI with each row having a different plan code & county. DHCS assumes that all lead CB-CMEs will have a NPI or be the MCP; if a CB-CME does not have an NPI #, please reach out to DHCS for further discussion. This is a measure of the prime contract with the MCP for care management duties, not engagement subcontractors or housing subcontractors.
Capacity for each CB-CME (Column D)	Enter the capacity for assigned HHP members for each CB-CME contracted in each county during the quarter. If a CB-CME operates in more than one county, separate the projected capacity for each county. Capacity is defined as the number of HHP members the CB-CME will be able to serve according to the HHP service requirements including the care manager ratio and the extent the CB-CME is able to satisfy all care team requirements. The count is taken at a point in time, which will be the last day of the quarter.
5. Health Home Program Annual CMS Core Measures Reporting	

DHCS is required to collect and report the Core Set of Health Care Quality Measures for Medicaid Health Homes Programs according to the Technical Specifications published by CMS. DHCS will continue to make the annual Technical Specification link available to the MCPs. MCPs are required to follow the technical specifications. DHCS will use the reporting template to collect measure information from the MCPs so that DHCS can perform the aggregation, weighting, and reporting required by the Technical Specifications. For additional information on the Core Measures, refer to the Technical Specifications and Resource Manual link from CMS. Approve the license agreements and download the Technical Specifications.

https://www.medicaid.gov/license-agreement.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-home-information-resource-center%2Fdownloads%2FFFY-18-HH-Core-Set-Manual.pdf

Each MCP will determine its numerator, denominator, and/or rates for the required performance measure and report these results for each county. DHCS is required to report separately for each SPA, therefore, there are separate numerator, denominator, and rates columns for Chronic Conditions and SMI. The Technical Specifications measurement year and reporting year definitions are consistent with DHCS's other HEDIS oriented timelines. The Technical Specifications require reporting results when the SPA is in effect for six or more months of the measurement period. The fields in the template will be adjusted over time to align with the Technical Specifications if/when they change.

Note: **This tab is to be submitted annually in the Q1 report (due 5/31) of every year and include data on the previous calendar year of January through December.**

Column Name	Explanation
Plan Code - Plan Name - County (Column A)	From the drop down menu, select the plan code, plan name and county combination for each county and plan code the plan operates in. Submit only one row of data per county that the MCP is in. Do not report subcontracting health plans separately. Report on data based on the member's assigned county.
Reporting Period (Column B)	From the drop down menu, select the corresponding year for the data reported: Year.
Controlling high blood pressure (CBP) (Med) age 18-59 w/HTN, BP < 140/90 - numerator (Column C)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (Med) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column D)	Controlling high blood pressure (Medical SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column E)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator

CBP (Med) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column F)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column G)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column H)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column I)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column J)	Controlling high blood pressure (Medical SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column K)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (Med) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column L)	Controlling high blood pressure (Medical SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - numerator (Column M)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - numerator
CBP (SMI) - Age 18-59 w/HTN, BP < 140/90 - denominator (Column N)	Controlling high blood pressure (SMI SPA) - Age 18-59 with hypertension, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - numerator (Column O)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/DIB, BP < 140/90 - denominator (Column P)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - numerator (Column Q)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - numerator
CBP (SMI) - Age 65-85 w/HTN, w/DIB, BP < 140/90 - denominator (Column R)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, with diabetes, BP < 140/90 - denominator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - numerator (Column S)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - numerator
CBP (SMI) - Age 60-64 w/HTN, w/o DIB, BP < 150/90 - denominator (Column T)	Controlling high blood pressure (SMI SPA) - Age 60-64 with hypertension, without diabetes, BP < 150/90 - denominator
CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - numerator (Column U)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - numerator

CBP (SMI) - Age 65-85 w/HTN, w/o DIB, BP < 150/90 - denominator (Column V)	Controlling high blood pressure (SMI SPA) - Age 65-85 with hypertension, without diabetes, BP < 150/90 - denominator
CDF (MED) - Age 12-17 - numerator (Column W)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - numerator
CDF (MED) - Age 12-17 - denominator (Column X)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 12-17 - denominator
CDF (MED) - Age 18-64 - numerator (Column Y)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - numerator
CDF (MED) - Age 18-64 - denominator (Column Z)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 18-64 - denominator
CDF (MED) - Age 65+ - numerator (Column AA)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - numerator
CDF (MED) - Age 65+ - denominator (Column AB)	Screening for clinical depression and follow-up plan (Medical SPA) - Age 65+ - denominator
CDF (SMI) - Age 12-17 - numerator (Column AC)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - numerator
CDF (SMI) - Age 12-17 - denominator (Column AD)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 12-17 - denominator
CDF (SMI) - Age 18-64 - numerator (Column AE)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - numerator
CDF (SMI) - Age 18-64 - denominator (Column AF)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 18-64 - denominator
CDF (SMI) - Age 65+ - numerator (Column AG)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - numerator
CDF (SMI) - Age 65+ - denominator (Column AH)	Screening for clinical depression and follow-up plan (SMI SPA) - Age 65+ - denominator
6. Health Home Program Reporting Comments	
Column Name	**Explanation**
Comments (Column A)	Enter any relevant information pertaining to the submitted report and the data it contains.

H. Appendix H – HHP Eligible Condition Diagnosis Codes

HHP Eligible Condition Diagnosis Codes

Asthma
J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.991, J45.998
CAD
I20.0, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.710, I25.720, I25.730, I25.750, I25.751, I25.758, I25.759, I25.760, I25.790, I25.811, I25.82, I25.83, I25.84, I25.89, I25.9, Z95.1, Z95.5, Z98.61
CHF
I09.81, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
COPD
J41.0, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Dementia
F01.50, F01.51, F02.80, F0281, F03.90, F03.91, F04, F05, F06.8, F07.0 , F07.81 , F07.89, F09 , F48.2, G30.9 , G31.01, G31.09 , G31.1 , G31.83 , R41.81
Diabetes
E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, R81, Z46.81, R82.4 Z96.41

HHP Eligible Condition Diagnosis Codes

Hypertension
I10, I67.4, I11.9, I11.0, I12.9, I12.0, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9, N26.2,
Liver Disease
K72.00, K74.0, K74.60, K74.69, K74.3, K74.4, K74.5, K75.81, K76.0, K76.89, K74.1, K74.2, K76.9, K75.0, K75.1, K70.41, K71.11, K72.01, K72.90, K72.91, K76.6, K76.7, K72.10, K72.11, K76.1, K76.3, K76.5, K76.81, K77, R17, R18.8, Z48.23, Z94.4
TBI
S01.90XA, S01.90XD, S04.011S, S04.012S, S04.019S, S04.02XS, S04.031S, S04.032S, S04.039S, S04.041S, S04.042S, S04.049S, S04.10XS, S04.11XS, S04.12XS, S04.20XS, S04.21XS, S04.22XS, S04.30XS, S04.31XS, S04.32XS, S04.40XS, S04.41XS, S04.42XS, S04.50XS, S04.51XS, S04.52XS, S04.60XS, S04.61XS, S04.62XS, S04.70XS, S04.71XS, S04.72XS, S04.811S, S04.812S, S04.819S, S04.891S, S04.892S, S04.899S, S06.0X0A, S06.0X0D, S06.0X0S, S06.0X1A, S06.0X1D, S06.0X1S, S06.0X2A, S06.0X2D, S06.0X2S, S06.0X3A, S06.0X3D, S06.0X3S, S06.0X4A, S06.0X4D, S06.0X4S, S06.0X5A, S06.0X5D, S06.0X5S, S06.0X6A, S06.0X6D, S06.0X6S, S06.0X7A, S06.0X7D, S06.0X7S, S06.0X8A, S06.0X8D, S06.0X8S, S06.0X9A, S06.0X9D, S06.0X9S, S06.1X0A, S06.1X0D, S06.1X0S, S06.1X1A, S06.1X1D, S06.1X1S, S06.1X2A, S06.1X2D, S06.1X2S, S06.1X3A, S06.1X3D, S06.1X3S, S06.1X4A, S06.1X4D, S06.1X4S, S06.1X5A, S06.1X5D, S06.1X5S, S06.1X6A, S06.1X6D, S06.1X6S, S06.1X7A, S06.1X7D, S06.1X7S, S06.1X8A, S06.1X8D, S06.1X8S, S06.1X9A, S06.1X9D, S06.1X9S, S06.2X0A, S06.2X0D, S06.2X0S, S06.2X1A, S06.2X1D, S06.2X1S, S06.2X2A, S06.2X2D, S06.2X2S, S06.2X3A, S06.2X3D, S06.2X3S, S06.2X4A, S06.2X4D, S06.2X4S, S06.2X5A, S06.2X5D, S06.2X5S, S06.2X6A, S06.2X6D, S06.2X6S, S06.2X7A, S06.2X7D, S06.2X7S, S06.2X8A, S06.2X8D, S06.2X8S, S06.2X9A, S06.2X9D, S06.2X9S, S06.300A, S06.300D, S06.300S, S06.301A, S06.301D, S06.301S, S06.302A, S06.302D, S06.302S, S06.303A, S06.303D, S06.303S, S06.304A, S06.304D, S06.304S, S06.305A, S06.305D, S06.305S, S06.306A, S06.306D, S06.306S, S06.307A, S06.307D, S06.307S, S06.308A, S06.308D, S06.308S, S06.309A, S06.309D, S06.309S, S06.310A, S06.310D, S06.310S, S06.311A, S06.311D, S06.311S, S06.312A, S06.312D, S06.312S, S06.313A, S06.313D, S06.313S, S06.314A, S06.314D, S06.314S, S06.315A, S06.315D, S06.315S, S06.316A, S06.316D, S06.316S, S06.317A, S06.317D, S06.317S, S06.318A, S06.318D, S06.318S, S06.319A, S06.319D, S06.319S, S06.320A, S06.320D, S06.320S, S06.321A, S06.321D, S06.321S, S06.322A, S06.322D, S06.322S, S06.323A, S06.323D, S06.323S, S06.324A, S06.324D, S06.324S, S06.325A, S06.325D, S06.325S, S06.326A, S06.326D, S06.326S, S06.327A, S06.327D, S06.327S, S06.328A, S06.328D, S06.328S, S06.329A, S06.329D, S06.329S, S06.330A, S06.330D, S06.330S, S06.331A, S06.331D, S06.331S, S06.332A, S06.332D, S06.332S, S06.333A, S06.333D, S06.333S, S06.334A, S06.334D, S06.334S, S06.335A, S06.335D, S06.335S, S06.336A, S06.336D, S06.336S, S06.337A, S06.337D, S06.337S, S06.338A, S06.338D, S06.338S, S06.339A, S06.339D, S06.339S, S06.340A, S06.340D, S06.340S, S06.341A, S06.341D, S06.341S, S06.342A, S06.342D, S06.342S, S06.343A, S06.343D, S06.343S, S06.344A, S06.344D, S06.344S, S06.345A, S06.345D, S06.345S, S06.346A, S06.346D,

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Bipolar Disorder
F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
Major Depressive Disorder
F06.30, F06.31, F06.32, F06.33, F06.34, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39
Psychotic Disorders
F06.0, F06.2, F20.0, F20.1, F20.2, F20.3 , F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F44.89
Alcohol Related
F10.121, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250,

F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.921, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, G62.1, I42.6, K29.20, K29.21, K70.0, K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.9
Substance Related
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I. Appendix I – HHP Implementation Schedule

HHP Implementation Schedule

The California Department of Health Care Services (DHCS) announced that the implementation of the state's Health Homes Program (HHP) begins July 1, 2018. The counties included in each group and the phased implementation schedule are outlined in the table below:

County Implementation Schedule

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

J. Appendix J – HHP Supplemental Payment File

Please refer to the DHCS' *Technical Guidance – Consolidated Supplemental Upload Process for further information.*

K. Appendix K – Whole Person Care Pilot Interaction Guidance

Joint Medi-Cal Managed Care Health Plan and Whole Person Care Pilot Guidance:

Eligibility and Provision of Services in the Health Homes Program and

Whole Person Care Pilots

This notification provides DHCS policy guidance regarding the eligibility, enrollment and the provision of services for Medi-Cal beneficiaries concurrently eligible for both the Health Homes Program (HHP) and a Whole Person Care (WPC) Pilot.

Medi-Cal managed care health plans (MCPs) implementing the HHP are responsible for providing the following six core HHP services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots are administered at the local level where a county, a city and county, a health or hospital authority, or a consortium of any of the above can serve as the Lead Entity (LE). WPC eligibility is established by each Pilot.

DHCS' guidance is that Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

In most cases WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program. If a Medi-Cal beneficiary is eligible for both WPC and HHP, the member may choose which program's care coordination services that want to receive. The member may not receive duplicative care coordination services from both WPC and HHP. If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC. The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

If the beneficiary chooses to receive care coordination services through WPC and is also interested in participating in the HHP, the beneficiary will not be able to receive any HHP services due to HHP, by default, being a program that consists of a set of 6 care-coordination services that are offered as the core benefit of the program.

In most cases WPC pilots also provide other services that are not duplicative, or similar to, HHP care coordination services. A sobering center service is one example of a WPC service that is likely to not be duplicative of HHP services. If a member is eligible for both WPC and HHP, and the member chooses to receive care coordination services through the HHP, the member may still receive other WPC services (that are not duplicative of HHP services) through the WPC. The WPC pilot may claim reimbursement for these other services regardless of whether the beneficiary chooses to receive care coordination services through the WPC or the HHP.

Please see the following points regarding DHCS' expectations:

- All WPC LEs must ensure the non-duplication of services for their WPC-enrolled members.

- The LEs are required to check other program participation, including HHP, as a regular part of their assessments. DHCS recommends frequent communication between the LE and their local MCPs to ensure there is no duplication of services.

- The WPC "Certification of Lead Entity Reports" document has been revised to include an additional attestation stating that DHCS reserves the right to recoup payments made to LEs for services found to be duplicative.

- LEs are responsible for keeping auditable records, such as documentation of their in-person assessments of enrollee participation in other programs, which should address non-duplication of services.

- As always, DHCS reserves the right to perform an audit of LE data and MCP data.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

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

June 06, 2019

NOTICE OF REQUEST FOR PROPOSALS (RFP)

#19-021A

GENERAL CONDITIONS AND INSTRUCTIONS TO OFFERORS

For

Health Homes Program Select Services – Revised

Key RFP Dates

Written Questions Due: June 24, 2019, 2:00, PM Pacific Time
Proposal Submittal Date: July 11, 2019, 2:00 PM Pacific Time

Back to Agenda Back to Item

Inviting Request for Proposals (RFP) 19-021A for Health Homes Program Select Services - Revised

CalOptima invites Proposals from qualified Offerors to provide Health Homes Program Select Services - Revised. Proposals shall be prepared and submitted in accordance with the requirements set forth in this RFP #19-021A. **Proposals must be submitted via BidSync no later than 2:00 PM Pacific Time, July 11, 2019.**

Proposals, and amendments to Proposals received after the date and time specified above will be rejected by the BidSync program and will not be delivered to CalOptima.

CalOptima's Basic Philosophy: Contracting for Results

CalOptima's fundamental commitment is to contract for results. CalOptima defines a successful result as a generation of defined, measurable, and beneficial outcomes that satisfy the contract requirements and support CalOptima's mission and objectives. This RFP 19-021A describes what is required of the successful Offeror in terms of services, deliverables, performance measures and outcomes, and unless otherwise noted in this RFP, places the responsibility for how they are accomplished on the successful Offeror.

Contract Elements

The term "contract" means the contract awarded as a result of this RFP 19-021A and all exhibits thereto. (See RFP Attachment 4: CalOptima Sample Contract). The successful Offeror/s will be required to accept a written contract in accordance with and included as a part thereof, this Request for Proposal, including all requirements, conditions and specifications contained therein. The Proposal, including all attachments and information on services, and associated pricing shall be binding and shall be incorporated into the written contract. At a minimum, the following documents will be incorporated into the contract:

- This RFP 19-021A and all attachments and exhibits.
- Any modifications, addendum or amendments issued in conjunction with this RFP 19-021A.
- The successful Offeror's Proposal.

Should there be any conflict between RFP 19-021A and the contract, the terms and conditions of the contract shall prevail.

It should be noted that as a public agency, CalOptima is mandated by various government entities to incorporate many of the terms and conditions listed within the entities Contract and BAA, and is unable to modify them in any way.

CalOptima is permitting each Offeror to identify the terms of the Contract and BAA it would like to negotiate. Using Attachment 5 entitled "Request to Negotiate Contract/BAA Terms," Offerors must identify the Current Language, Proposed Language, and Rationale for the

Request. Note that any request to negotiate contract terms without a rationale will not be considered for negotiation. CalOptima will evaluate all requests and render a decision on each Contract/BAA term identified.

If a "Request to Negotiate Contract/BAA Terms" form is not submitted with the proposal, the terms submitted in the Sample Contract will be in force. CalOptima will not review any changes marked on the Contract/BAA PDFs that are not included on the "Request to Negotiate Contract/BAA Terms" form. CalOptima will also not review any additional terms & conditions submitted by Vendor on Vendor paper. Even if you currently have an existing contract/BAA with CalOptima or have had one in the past, the services within this RFP are considered separate and CalOptima **will not** add them to an existing agreement.

Each deletion, addition, and modification, etc., to CalOptima's Sample Contract or BAA must be logged and submitted on the "Request to Negotiate Contract Terms" form. Failure to do so will result in your proposal being deemed non-responsive. Even if you currently have a contract or BAA with CalOptima or have had one in the past, a "Request to Negotiate Contract Terms" form must be created and included as part of your firms' proposal.

CalOptima may disqualify and terminate negotiations with any Offeror that did not take exception to a given Sample Contract or BAA provision in its proposal and subsequently attempts to do so during negotiations. As such, it is in Offeror's best interest to have the Sample Contract reviewed by counsel prior to submitting a proposal.

The successful Offeror will be required to comply with all applicable equal opportunity laws and regulations.

Sincerely,

Ryan Prest
Purchasing Manager

Table of Contents

List of RFP Attachments

SECTION I: CALOPTIMA BACKGROUND AND OVERVIEW

A. County Organized Health Systems (COHS) Background

The California State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972, Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category.

In June 1983, a new type of managed care program, the County Organized Health System (COHS), became operational. The COHS managed care model ensures Med-Cal recipients access to comprehensive, cost-effective health care. Each COHS plan is sanctioned by the County Board of Supervisors and governed by an independent commission.

B. CalOptima Overview

CalOptima's Overview can be located by clicking on the following link and by selecting 'View CalOptima Fast Facts": https://www.caloptima.org/AboutUs.aspx

SECTION II: INSTRUCTIONS AND CONDITIONS

A. General Requirements

1.0 This RFP 19-021A contains a list of requirements for the successful Offeror. A qualified Offeror, for the purpose of this RFP 19-021A, is an Offeror that can reliably, competently and independently provide the required services to CalOptima for the entire term of the agreement. The contract term is One (1) year with Three (3), one year renewal options at CalOptima's discretion.

2.0 As required under Ordinance No. 3896 of the County of Orange, State of California, Offeror hereby acknowledges and agrees that the obligations of CalOptima under any resulting contract are solely the obligation of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

B. Instructions and Conditions

1.0 Examination of Proposal Documents

1.1 Before submitting a Proposal, each Offeror represents that it has thoroughly examined and become familiar with the work required under this RFP 19-021A and it is capable of performing quality work to achieve CalOptima's objectives.

1.2 Each Offeror must be satisfied by personal examination, and by such other means as it may prefer, as to the actual conditions and requirements under which the contract will be performed.

1.3 CalOptima reserves the right to remove from its list for future RFPs, for an undetermined period of time, the name of any Offeror for failure to accept a contract, failure to respond to two consecutive RFPs and/or unsatisfactory performance. Please note that a "No Bid" is considered a response.

2.0 Addenda

CalOptima may make changes to the requirements of this RFP 19-021A. Any CalOptima changes to the requirements will be made by written addendum to this RFP 19-021A. Any written addenda issued pertaining to this RFP 19-021A shall be incorporated into the terms and conditions of any resulting contract. CalOptima will not be bound to any modifications to, or deviations from, the requirements set forth in this RFP 19-021A as the result of oral instruction. All addenda will be submitted by CalOptima via BidSync.

3.0 Procurement Schedule

The following table presents the anticipated schedule for this procurement. All dates are subject to change at CalOptima's discretion. Changes to the schedule will be communicated via an addendum to this RFP through BidSync.

Event	Date
RFP 19-021A Issue Date	June 06, 2019
Written Questions due from Offerors via BidSync	June 24, 2019
Responses to Questions due from CalOptima via BidSync	June 27, 2019
Proposals due from Offerors via BidSync	July 11, 2019
Demonstrations/Interviews/Site Visits/Reference Checks	August 05 - 08, 2019
Vendor Selection	August 14, 2019

4.0 Procurement Point-of-Contact

4.1 All communications relating to this RFP 19-021A must be directed to CalOptima's designated contact below:

Ryan Prest
rprest@caloptima.org
CalOptima Vendor Management Department
505 City Parkway West
Orange, CA 92868

4.2 Any and all communications relating to this RFP must be directed to the Vendor Management Point-of-Contact named above. Communications relating to this RFP between respondents and other CalOptima staff members concerning this RFP are strictly prohibited. Failure to comply with these requirements will result in Proposal disqualification.

5.0 Questions and Clarifications

5.1 If an Offeror desires an explanation or clarification of any kind regarding a provision of this RFP 19-021A, the Offeror must generate a written request for such explanation or clarification through BidSync by 2:00, PM Pacific Time, June 24, 2019. Inquiries received after 2:00 PM Pacific Time, June 24, 2019 will not be responded to.

5.2 CalOptima responses will be communicated via BidSync, and will be sent no later than 5:00 PM Pacific Time, June 27, 2019.

6.0 Proposal Preparation

6.1 Proposals shall be typed in 12 point font and submitted via BidSync in a Word, Excel or PDF format. Do not provide zip files. Offerors should not include any unnecessarily elaborate or promotional material.

6.2 Information shall be presented and submitted through BidSync and must be submitted in the order in which it is requested. Please limit your responses to no more than five (5) documents. Each file name must contain your company name and RFP number. The responses must directly address the items requested in each requirement. Complete, concise and specific responses are required. Lengthy narrative is discouraged.

6.3 Letter of Transmittal

A mandatory Letter of Transmittal shall be included with the Proposal and must, at a minimum, contain the following:

- Identification of Offeror, including name, address and telephone number.
- Name, title, e-mail address and telephone number of Offeror's representative during the period of proposal evaluation.
- Proposed working relationship between Offeror and subcontractors, and if not applicable, indicate so.
- A statement to the effect that the Proposal shall remain valid for a period of not less than 150 calendar days from the Proposal due date.
- Signature of a person authorized to bind Offeror to the terms of the Proposal.
- Either a statement indicating no contract changes or submit a Request to Negotiate Contract Terms as presented in this RFP as Attachment 5).
- A statement clarifying if you are bidding on one or both or the available select services.

7.0 Proposal Submittal

7.1 Date and Time

All Proposals must be submitted via BidSync and must be submitted no later than 2:00 PM Pacific Time, July 11, 2019. CalOptima recommends you begin the submission process well in advance of the proposal submission deadline to allow ample time for transmission.

7.2 Acceptance of Proposals

7.2.1 CalOptima reserves the right to accept or reject any and all proposals, or any item or part thereof, or to waive any informalities or irregularities in proposals.

7.2.2 CalOptima reserves the right to withdraw this RFP at any time without prior notice and CalOptima makes no representations that a contract will be awarded to any Offeror responding to this RFP.

7.2.3 CalOptima reserves the right to postpone proposal opening for its own convenience.

8.0 Pre-Contractual Expenses

8.1 Pre-contractual expenses are defined as expenses incurred by the Offeror in:

- preparing its proposal in response to this RFP;
- submitting its proposal to CalOptima;
- negotiating with CalOptima on any matter related to its proposal; or
- any other expenses incurred by the Offeror prior to date of award, if any, of the contract.

8.2 CalOptima shall not, in any event, be liable for any pre-contractual expenses incurred by Offeror in the preparation of its proposal. Offeror shall not include any such expenses as part of its proposal.

9.0 Joint Offers

Where two or more Offerors desire to submit a single proposal in response to this RFP 19-021A, they should do so on a prime-subcontractor basis rather than as a joint venture. CalOptima intends to contract with a single firm and not with multiple firms doing business as a joint venture.

10.0 Non-Collusion Affidavit

As part of its Proposal, Offerors are required to complete and sign the Non-Collusion Affidavit provided as RFP Attachment 2. Proposals submitted to CalOptima without a fully executed copy of the Non-Collusion Affidavit will be considered non-responsive.

11.0 Contract Type and Term

11.1 It is anticipated that the contract resulting from this solicitation, if awarded, will be a firm-fixed price contract unless otherwise specified.

11.2 The initial term of any resulting agreement shall be for a period of One (1) year, with an anticipated effective date of TBD, with Three (3) consecutive, one year renewal options at CalOptima's discretion.

12.0 Eligibility for Contract Award

CalOptima will not award this RFP or enter into a contract with any Offeror who is debarred, suspended or otherwise ineligible for the award of a contract or grant by any Federal agency or from participating in Federal Healthcare Programs. By submission of this proposal, Offeror

acknowledges and warrants that the Offeror and any of its officers, directors, owners, partners, or any person having primary management or supervisory responsibilities within the Offeror's business are not presently debarred, suspended, proposed for debarment or declared ineligible for the award of contracts by any Federal agency or from participating in any Federal healthcare programs. Offerors must complete RFP Attachment 3 entitled "Offeror Eligibility Certification" and submit as part of its proposal.

13.0 Withdrawal of Offers

Offers may be withdrawn only by signature of Offeror, provided the request is received by the person whose duty it is to open proposals prior to the time fixed for proposal opening. Each proposal opened will be considered to be a valid offer.

14.0 Use of Offeror Response and Accompanying Material

14.1 All materials submitted become the property of CalOptima and will not be returned. If the Offeror intends to submit confidential or proprietary information as part of the proposal, any limits on the use or distribution of that material should be clearly delineated in writing. However, CalOptima is a public agency and therefore subject to the California Public Records Act (California Government Code, Section 6250 et seq).

14.2 CalOptima will use reasonable precautions allowed by law to avoid disclosure of the Offeror proposal. CalOptima reserves the unrestricted right to copy and disseminate the Offeror proposals for internal review and for review by external advisors, at CalOptima's sole discretion.

15.0 Evaluation and Award of Contract

15.1 Issuance of this RFP 19-021A or receipt of proposals does not commit CalOptima to award a contract. CalOptima reserves the right to withdraw this RFP 19-021A at any time without further notice and, furthermore, makes no representation that any contract will be awarded to any Offeror responding to this RFP 19-021A. CalOptima expressly reserves the right to postpone proposal opening for its own convenience; to accept or reject any or all proposals received in response to this RFP 19-021A; to waive informalities and minor irregularities in bids received; to reject any and all proposals responding to this RFP 19-021A without indicating any reasons for such rejection; to negotiate with other than the selected Offeror should negotiations with the selected Offeror be terminated; to negotiate with more than one Offeror simultaneously or to cancel all or part of this RFP 19-021A.

15.2 In no event will CalOptima be limited to selecting a successful Offeror based solely upon total cost submitted. Evaluation of the Proposals shall be generally based upon the reasonableness of price; experience in the market; capabilities of the Offeror to effectively complete the project requirements; financial stability and completeness of the Proposal response and the requested data. All proposals received as specified will be evaluated by CalOptima staff in accordance with the above criteria and additional sub-criteria that may be considered as relevant or pertinent by the evaluators.

15.3 In accordance with CalOptima's purchasing policy, CalOptima staff may select one or more responsive, responsible Offeror(s) whose Proposal(s) are most advantageous to CalOptima– price, quality and other factors considered.

15.4 False, incomplete, or unresponsive statements in connection with a Proposal may be cause for rejection. The evaluation and determination of fulfillment for the above requirements shall be in CalOptima's sole judgment and this judgment shall be final. Any Proposal not meeting terms and conditions may be rejected.

15.5 Offerors who submit a proposal in response to this RFP 19-021A shall be notified in writing regarding whether its firm was awarded the contract or not. Such notification shall be made within a reasonable time after the date the contract is executed.

16.0 Exceptions/Deviations

16.1 CalOptima requires each Offeror to state any exceptions to or deviations from the requirements of this RFP 19-021A, separating "technical" exceptions from "contractual" exceptions. Where Offeror wishes to propose alternative approaches to meeting CalOptima's technical requirements, these should be thoroughly explained.

16.2 Each deletion, addition, and modification, etc. to CalOptima's contract or BAA must be logged and submitted in the "Request to Negotiate Contract/BAA Terms" form (Attachment 5 of this RFP). Failure to do so will result in your firm's proposal being deemed non-responsive. Even if you currently have a contract or BAA with CalOptima or have had one in the past, the services within this RFP are considered separate and CalOptima will not add them to an existing agreement.

17.0 Appendices

Information considered by Offeror to be pertinent to this project and which has not been specifically solicited in any of the aforementioned sections may be placed in a separate appendix section. Offerors are cautioned, however, that this does not constitute an invitation to submit large amounts of extraneous materials; appendices should be relevant and brief.

18.0 Non-Solicitation of Employees

Neither CalOptima nor CONTRACTOR shall solicit nor hire any personnel of the other during the Term of this Contract, or for a period of one year following the termination of this Contract, without the consent of the other party.

SECTION III: TECHNICAL AND PRICE PROPOSAL REQUIREMENTS

A. Technical Proposal Requirements

1.0 Corporate Capabilities

1.1 Qualifications and Experience

1.1.1 Provide a brief profile of the firm, including the types of services offered; the year founded; form of the organization (corporation, partnership, sole proprietorship); number, size and location of offices; number of employees.

1.1.2 Briefly describe the background of the company, including the formation, implementation of new business, sales, mergers, acquisitions, ownership, current lines of business and intended future lines of business. If applicable, indicate action to prevent disruption of current and/or new business.

1.1.3 Identify the senior management staff and their length of time with the company. Identify management staff that would be directly involved with the CalOptima contract and their length of time with the company.

1.1.4 Identify three (3) references of clients similar in scope and complexity to that of CalOptima. References shall include the name, title, email address, and telephone number of the person at the client organization who is most knowledgeable about the work.

1.1.5 Indicate any past or current material disputes including litigation with customers, provider groups, government entities, client groups and any other litigation with contingent liability of $500,000 or more. State the results or status of the dispute.

1.1.6 Is your company under investigation or being sued by any governmental agency? Has your company been barred from participation in a publicly-funded health program (such as Medicare or Medicaid)? If yes, provide a detailed explanation of the circumstances and status.

1.1.7 Provide details of any inquiry letters and/or negative audit results received from any state or federal agency or any outside business auditor.

1.1.8 Has your organization been audited in accordance with the Statements for Standards on Attestation Engagements (SSAE) 16 (formerly SAS 70 audit)? If yes, were any exceptions noted? If not audited, please explain.

1.1.9 If the respondent proposes to use subcontractor(s), it must describe any existing or ongoing relationships with the subcontractor(s); including project descriptions and the portions(s) of this RFP intended to be subcontracted

1.1.10 Identify subcontractors by company name, address, contact person, telephone number and project function and describe Offeror's experience working with each subcontractor.

2.0 Information Processing System (If you are proposing use of any systems, please complete)

2.1 Describe the current information processing system(s) used, highlighting features that ensure flexibility, timely updates of files, table-driven parameters, managed care orientation and timely, appropriate enhancements.

2.2 Describe the number, variety and location of processing platforms you use today. Are you planning a migration or consolidation of your system platforms? Describe the process, including testing and timeframes. Identify which platform(s) will be used to administer CalOptima's program.

2.3 Describe the security options related to user login and levels of security available by user profile.

2.4 Complete RFP Attachment 6: Security Questionnaire to describe your firm's standards for security, privacy, compliance and risk management and adherence to industry and government best practices.

2.5 Indicate the location and capacity of your data center(s). Describe your information systems disaster and recovery plans and identify applicable locations.

2.6 Quantify your application/system downtime monthly from January 1, 2015 to current. Identify scheduled and unscheduled downtime separately.

2.7 Do you operate your information processing system or do you have a subcontractor or vendor operate the system? If you are using a subcontractor(s), include the name(s).

2.8 Do you own the source code and manage all version upgrades, maintenance and application modifications internally? If not, use the table format below to identify entities and services performed.

System Subcontractors/Vendors					
Company Name	**Contact Name**	**Telephone**	**E-Mail**	**System/ Application Supported**	**Service Provided**

2.9 Can the software be customized to meet CalOptima's specific needs, including Programming/development integration, APIs and interfaces?

2.10 Can 18 months of past utilization from other systems be loaded and maintained within your system? Please describe any limitations.

2.11 How does the software access within and across the public Internet? Does the software have web-browser access? Describe the features of your member web portal.

2.12 Describe in detail all available web functionality and tools that will be made available to CalOptima through any resulting agreement.

2.13 Itemize required software and hardware to be installed/operational by CalOptima to achieve on-line connectivity to your organization. Will you supply all or some required software and hardware for on-line connectivity? Identify these items specifically and in the Price Proposal.

2.14 What is the process and format used to transfer data to CalOptima?

2.15 Describe the design, development and implementation processes used to update and modify the current information processing system software to maintain client requirements and industry standards.

- Are system updates done on a client-specific basis or on a cyclical basis for all or multiple clients?
- Confirm your commitment to maintain the software and to provide "bug" fixes and work-around solutions.
- Provide a summary of updates in-progress or planned. What abilities and timeframes will CalOptima have to test the upgrade prior to implementation?
- CalOptima expects to receive updates and new versions at no additional fee during the contract period. Confirm that updates and new versions will be made available on this basis to CalOptima.
- Indicate if CalOptima has the option of declining or postponing implementation of system changes or enhancements.

3.0 Financial Management

3.1 Provide evidence of financial stability sufficient to demonstrate reasonable stability and solvency appropriate to the requirements of this procurement:

3.1.1 If the respondent is a corporation that is required to report to the Securities and Exchange Commission, it must submit its two most recent SEC Forms 10K, Annual Reports.

3.1.2 If the respondent is *not* a corporation that is required to report to the Securities and Exchange Commission, it must submit its current financial statement plus previous two (2) years of audited financial reports including all supplements, management discussion and analysis, and actuarial options.

3.1.2.1 At a minimum, such financial statements and reports shall include: balance sheet; statement of income and expenses (also referred to as "statement of profit and loss"); statement of changes in financial position; cash flows; and capital expenditures.

3.1.3 If any change in ownership is anticipated during the twelve (12) months following the proposal due date, the respondent must describe the circumstances of such change and indicate when the change is likely to occur.

3.1.4 The respondent must identify any conditions (e.g., bankruptcy, pending litigation, planned office closures, impending merger) that may impede Offeror's ability to complete the project.

3.2 Include a copy of your billing invoice as part of your firms' proposal.

4.0 Proposed Staffing and Project Organization

4.1 Provide education, experience and applicable professional credentials of project staff.

4.2 Furnish brief resumes (not more than two [2] pages each) for the proposed Project Manager, Account Manager, and other key personnel.

4.3 Indicate adequacy of labor resources utilizing a table projecting the labor-hour allocation to the project by individual task.

4.4 Identify key personnel proposed to perform the work on the specified tasks and include major areas of subcontract work.

4.5 Include a project organization chart which clearly delineates communication/reporting relationships among the project staff.

4.6 Include a statement that key personnel will be available to the extent proposed for the duration of the project, acknowledging that no person designated as "key" to the project shall be removed or replaced without the prior written concurrence of CalOptima.

4.7 Identify the individuals who will be assisting with implementation, contract rollout, reporting and system questions. Include a list of qualifications and credentials for those individuals. Identify if any of these individuals continue in ongoing operation roles.

4.8 Describe the roles, responsibilities and deliverables of CalOptima and the Offeror during the implementation phase in a detailed work plan. The work plan must outline sequentially and describe the elements and activities that would be undertaken in completing the tasks; specify by name and job description, the person Offeror would assign to perform said task; the hourly rate of each person; rate for task identified; and include a schedule for completing the tasks in terms of elapsed weeks from the commencement date. Include details regarding the timeline needed before system is capable of being "live" for use after contract execution.

4.9 Describe in detail, the timeline dependencies for availability of required data feeds and interfaces to CalOptima systems in order to implement Offeror s system successfully based upon the timeline you propose.

4.10 What CalOptima resources are required by Offeror to meet the implementation timeframe?

B. Price Proposal Requirements

CalOptima is anticipating and hourly-rate bid for these types of services. If your firm would prefer to bill a different way, please submit that as a secondary offering to the RFP so we can review both options. If you are bidding for both services, please make sure your pricing is separate for each so we can evaluate all bidders for each specific service.

The successful Offeror shall not be allowed to invoice CalOptima throughout the duration of any resulting contract for any pricing not listed within the following pricing form. Pricing data contained in other areas of the Offeror's Proposal will not be considered.

C. Scope of Work

CalOptima is requesting proposals for two separate Health Homes Programs Select Services. They are:

- OBJECTIVE A - HHP Select Services - Housing Services
- OBJECTIVE B - HHP Select Services – Accompaniment Services

Interested bidders can bid on one of both of the select services below.

I. BACKGROUND

CalOptima contracts on a full or partial risk capitated basis with its delegated Health Maintenance Organizations and provider-sponsored organizations, known as Physician Hospital Consortia and Shared Risk Groups (jointly referred to as Health Networks), to provide care to approximately 75% of CalOptima members. Health Networks (HNs) are financially responsible according to their contract agreement to provide medically necessary services to their assigned members.

CalOptima serves the remaining members through a fee-for-service program known as "CalOptima Direct". CalOptima Direct network includes members who select to be in CalOptima Community Network (CCN) and members who are in specific categories (e.g., members with share of costs,

members with both Medicare and Medi-Cal) who are unable to select another network and would be served through the CalOptima Direct – Administrative program.

Health Homes Program (HHP)

The Federal Patient Protection and Affordable Care Act (ACA) Section 2703 authorizes the Medicaid Health Home State Plan Option. In California, Assembly Bill 361 (2013) authorizes implementation of the Health Home Program (HHP). Statewide, HHP will be implemented in selected counties with Medi-Cal Managed Care Plans (MCPs) operating as lead entities. CalOptima, along with other selected counties in California are implementing HHP on a phased basis:

- No sooner than January 1, 2020 for CalOptima members with eligible chronic physical conditions and substance use disorder (SUD); and,
- No sooner than July 1, 2020 for members with Serious Mental Illness (SMI) and/or Seriously Emotional Distress (SED).[1]

DHCS has developed the "Health Homes for Patients with Complex Needs Program", including person-centered coordination to improve member outcomes through two objectives:

- Coordination of physical health services, mental health services, substance use disorder services, community-based LTSS, palliative care, and social support needs; and,
- Reduction of avoidable health care costs, including hospital admission/readmissions, Emergency Department visits, and nursing facility stays

DHCS is targeting the top 3-5% highest risk/utilizing Medi-Cal members with specific multiple chronic physical conditions aligned with certain acuity criteria, or SMI whose outcomes may improve through HHP interventions. In summary, CalOptima Medi-Cal members must meet criteria established by DHCS including both of the 'chronic condition' and 'acuity' requirements. CalOptima's Medicare and members dually eligible for Medicare and Medi-Cal can participate through referrals only if eligibility criteria are met. Part of the HHP eligible members may meet HHP eligibility criteria of 'Chronic Homeless'. Details on these eligibility requirements and exclusion criteria can be found in the HHP Program Guide available at the following link: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx .

DHCS has identified the following six (6) HHP core services and expects these services to be available to all members enrolled in HHP:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support Services; and,
6. Referral to Community and Social Supports, including housing navigation and sustainability services.

Pursuant to the DHCS Program Guide and All Plan Letter 18-012: Health Homes Program Requirements, Managed Care Plans (MCPs) will be responsible for overall administration, including development of the HHP network. HHP services will be coordinated through Community Based-Care Management Entities (CB-CMEs). HHP services will be provided primarily by a CB-CME under

[1] *Reference California SPA: 18-020 for SMI/SED definition at* https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-18-0020.pdf

a contract with CalOptima as the HHP Lead Entity. CB-CMEs will be responsible to coordinate with members, existing providers and other agencies.

CalOptima expects to be the CB-CME for members assigned to CalOptima Direct. Since HNs already provide most HHP services under their delegated contract, CalOptima has delegated CB-CME responsibilities to HNs for their assigned members. HNs may be permitted to subcontract for some select HHP services.

II. OBJECTIVE A – Housing Services

The purpose of this RFP is to solicit proposals from HHP select service providers, henceforth referred to as "OFFERORS", interested in contracting with CalOptima to provide Health Homes Program (HHP) ***housing navigation and sustainability services***. OFFEROR services shall be provided to CalOptima's Medi-Cal members enrolled in HHP program. For ease of administration, consistency and scale, CalOptima will require OFFEROR to make HHP services hereunder available to HNs, either through CalOptima's contract or a separate contract with individual HNs choosing to contract with OFFEROR for such services.

OFFEROR may also extend similar services, terms and conditions for other Medi-Cal programs supporting homeless population including, but not limited to, Whole Person Care (WPC). Such programs are administered either by CalOptima and/or other entities including the Orange County Health Care Agency (OCHCA).

CalOptima has the option to award contracts to a single or multiple OFFEROR(s), as needed in an effort to ensure the required coverage for its members. CalOptima has the option to retain any partial services in-house.

OFFEROR services shall be available to all CalOptima HHP enrolled members assigned to CalOptima Direct and any HHP enrolled member assigned to a CalOptima delegated HNs choosing to contract with OFFEROR for such services. OFFEROR will provide such services according to contract terms and expectations outlined by each contracted entity.

OFFEROR shall work with each contracted entity as applicable to ensure seamless access to the delivery of services and utilize processes and tools required by each individual entity.

Housing Navigation and Sustainability Services

The OFFEROR of Housing Services must have one or more HHP designated staff, referred to as a "Housing Navigator", who will assist members experiencing homelessness or at risk of homelessness, as directed by the contracted entity, as applicable. CalOptima will accept an application from the OFFEROR even if the OFFEROR can provide only one of the two services listed below.

The OFFEROR of Housing Services must provide one or both of the following:

- Individual Housing Transition Services and
- Individual Housing and Tenancy Sustaining Services

1. Individual Housing Transition Services to assist members with obtaining housing, such as individual outreach and assessments. These services include:

A. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;

B. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;

C. Assisting with the housing application process;

D. Assisting with the housing search process;

E. Identifying and securing resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;

F. Ensuring that the living environment is safe and ready for move-in;

G. Assisting in arranging for and supporting the details of the move; and

H. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

I. Coordinating with the County for those HHP members that are also in the County's Coordinated Entry System as there may be housing vouchers or programs identified for the client through this system.

2. Individual Housing and Tenancy Sustaining Services, such as tenant and landlord education and tenant coaching, support individuals in maintaining tenancy once housing is secured. These services include:

A. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;

a) Providing a plan for the client in recognition of these behaviors

b) Providing a plan for the landlord (who to call) if the behaviors are noted

B. Education and training on the roles, rights and responsibilities of the tenant and landlord;

C. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;

D. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;

E. Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;

F. Ensuring that the member is connected to social supports in the vicinity of their new community and that the other service providers connected with the member also know they are newly housed.

G. Assisting the client in accessing resources that may be necessary to obtain immediate need items including, but not limited to: toiletries, cleaning products, kitchen ware, bed, towels and linens, and refrigerator.

H. Assistance with the housing recertification process;

a) Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and

b) Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

III. Performance Guarantee

OFFEROR commits to the performance as expected and comply with the Corrective Action Plan provided by CalOptima if failure to meet the requirements of the contract. CalOptima reserves the right to pursue compliance actions in accordance with CalOptima Policy HH.2002 and HH.2005.

IV. Claims Processing and Reporting

OFFEROR or its staff shall never charge a member directly for any service hereunder nor shall OFFEROR ever accept a gratuity from a member for such services.

DHCS has established a HIPAA compliant HHP specific HCPCS code 'G9008' which is defined as "Coordinated care fee, physician coordinated care oversight services". OFFEROR agrees to comply with all DHCS claims submission timeliness requirements. OFFEROR agrees to adhere to the Provider Dispute Resolution process according to DHCS requirements and CalOptima's expectations.

OFFEROR will use the following modifiers to identify non-clinical staff services, in-person and telephonic/telehealth 'visits', and other HHP services such as case notes documentation, case conferences, and tenant supportive services.

OFFEROR will use HCPCS code with corresponding modifier for billing and reporting as follows:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff, including case note documentation, case conferences and tenant supportive services	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed

V. Supplemental Information

CalOptima will evaluate OFFEROR based on all of the above requirements, service readiness as well as the responses to the "Supplemental Questionnaire" below. OFFEROR must respond as fully, accurately and completely as possible to each of the following questions as a part of its proposal response. OFFEROR shall respond with current state and how OFFEROR envisions meeting CalOptima's requirements.

All OFFERORs must provide information demonstrating:

A. Ability to capture, track and report the delivery of services described in Section II above.

B. Experience working with Medi-Cal members and/or similar racially, ethnically and culturally diverse populations.

C. Experience working with persons with multiple chronic conditions, SMI, and members experiencing homelessness.

D. Experience working with entities such as health networks, providers and county agencies and/or community-based organizations.

E. OFFEROR must submit their background check process for their staff for review by CalOptima.

F. Ability to hire, retain, manage and support paraprofessional or other staff with experience and knowledge of the population and processes specific to the designated service type as described below;

   a) If staff have insufficient required experience, please explain how OFFEROR would train staff to provide support services and participate in interdisciplinary care plans.

   b) Ability to provide services within two (2) business days of request.

   c) Ability to support members' need to speak in Orange County threshold languages.

G. Ability to receive, record and disseminate information about encounters with members , including services provided, findings, recommendations, referrals e.g., with member, health plan or other business partnerships involved in the care of members.

H. Confirm the ability to use tools created by CalOptima, to dedicate time for staff to train in use of these tools and to adopt internal processes (e.g., policies, desktops and reports) to track interventions, capture health outcomes, facilitate care planning and referral management.

I. Communication methods proposed to communicate with CalOptima and other contracted entities (such as health networks).

J. Current processes in place to handle urgent and emergent member grievances and coordinate resolution.

K. Experience working with Orange County Community Resources and target populations to ensure seamless access to the delivery of housing support services and to provide housing navigation services, not just referrals to housing, including:

   a) Working with individuals who are experiencing or may imminently be experiencing homelessness;
   b) Providing Individual Housing Transition Services, as described in Section II;
   c) Providing Tenancy Sustaining Services, as described in Section II;
   d) Working with Orange County housing agencies, permanent housing providers, including supportive housing providers, and other community-based organizations, Coordinated Entry process.
   e) Describe tools or standards that staff will follow to report or document the notes after services provided to each member.
   f) Describe OFFEROR's ability to be flexible with contracted entities to provide the same services with various expectations.

VI. OBJECTIVE B – Accompaniment Services

The purpose of this RFP is to solicit proposals from HHP select service providers, henceforth referred to as "OFFERORS", interested in contracting with CalOptima to provide Health Homes Program (HHP) ***accompaniment services.*** OFFEROR services shall be provided to CalOptima's Medi-Cal members enrolled in HHP program. For ease of administration, consistency and scale, CalOptima will require OFFEROR to make HHP services hereunder available to HNs, either through CalOptima's contract or a separate contract with individual HNs choosing to contract with OFFEROR for such services.

CalOptima has the option to award contracts to a single or multiple OFFEROR(s), as needed to ensure the required coverage for its members. CalOptima has the option to retain any partial services in-house.

OFFEROR services shall be available to all CalOptima HHP enrolled members assigned to CalOptima Direct and any HHP enrolled member assigned to a CalOptima delegated HNs choosing to contract with OFFEROR for such services. OFFEROR will provide such services according to contract terms and expectations outlined by each contracted entity.

OFFEROR shall work with each contracted entity as applicable to ensure seamless access to the delivery of services and utilize processes and tools required by each individual entity.

Accompaniment:

The OFFEROR of Accompaniment Service will be required to provide 'accompaniment' services to HHP members for medically necessary appointments in a timely manner (as described in the CalOptima Provider Manual, Section M6) as approved and requested by CalOptima and/or Health Networks according to the expectations outlined below:

A. Outreach to member in advance of scheduled appointment to coordinate, including to obtain appointment date and time, and to provide information on accompaniment process, what to expect at the appointment, identification of potential questions.
    a) On a case by case basis, as requested by CalOptima and/or Health Networks, discuss in advance of an appointment for special instructions.
    b) Contact member the business day prior to the appointment for reminder and confirmation of the appointment.
B. Provide same-day services to a member who needs accompaniment to an unplanned service such as urgent care or emergency department.
C. Traveling with member to an appointment or meeting member at provider office based upon member's need.
D. Attending appointment with member at clinical provider office as requested.
E. Members are expected to arrange their own transportation or request CalOptima to provide non-medical transportation to the appointment. OFFEROR is not permitted to drive member to the appointment or allow member to drive OFFEROR (staff) to the appointment.
F. CalOptima will identify HHP member for accompaniment services for specific appointment and notify OFFEROR.
G. CalOptima expects that most accompaniment will take place within Orange County.

a) CalOptima prefers OFFEROR to provide accompaniment throughout Orange County; CalOptima will accept proposals for services on a regional basis;

b) Out-of-county requests outside the ten (10) miles of Orange County may be required on a case-by-case basis.

H. OFFEROR must send to member and CalOptima, no later than 2 business days following the date of the appointment, a summary report of the discussion, questions raised, next appointment (if any) member next steps, and any referrals for follow-up by CalOptima. CalOptima and Health Network will provide standard form that OFFEROR will be required to complete.

I. OFFEROR must participate in care team meetings and implementing care plan, as requested. CalOptima and Health Network will notify OFFEROR and conduct Care team meetings outside of the member appointments.

VII. Performance Guarantee

OFFEROR commits to the performance as expected and comply with the Corrective Action Plan provided by CalOptima if failure to meet the requirements of the contract. CalOptima reserves the right to pursue compliance actions in accordance with CalOptima Policy HH.2002 and HH.2005.

VIII. Claims/Reimbursement Processing and Reporting

OFFEROR or its staff shall never charge a member directly for any service hereunder nor shall OFFEROR ever accept a gratuity from a member for such services.

DHCS has established a HIPAA compliant HHP specific HCPCS code 'G9008' which is defined as "Coordinated care fee, physician coordinated care oversight services". OFFEROR agrees to comply with all DHCS claims submission timeliness requirements. OFFEROR agrees to adhere to the Provider Dispute Resolution process according to DHCS requirements and CalOptima's expectations.

OFFEROR will use the following modifiers to identify non-clinical staff services, in-person and telephonic/telehealth 'visits', and other HHP services such as case notes documentation, case conferences, and driving to appointments.

OFFEROR will use HCPCS code with corresponding modifier for billing and reporting as follows:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Non-Clinical Staff, including accompaniment	G9008	U4	15 Minutes equals 1 UOS; Multiple UO allowed
Phone/Telehealth: Provided by Non-Clini Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UO allowed
Other Health Home Services: Provided by Non-Clinical Staff, including participation in ICT, care planning and driving to appointments.	G9008	U6	15 Minutes equals 1 UOS; Multiple UO allowed

IX. Supplemental Information

CalOptima will evaluate OFFEROR based on all of the above requirements, service readiness, as well as the responses to the "Supplemental Questionnaire" below. OFFEROR must respond as fully, accurately

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and completely as possible to each of the following questions as a part of its proposal response. OFFEROR shall respond with current state and how OFFEROR envisions meeting CalOptima's requirements.

All OFFERORs must provide information demonstrating:

A. Ability to capture, track and report the delivery of services described in Section II above.

B. Experience working with Medi-Cal members and/or similar population racially, ethnically and culturally diverse populations.

C. Experience working with persons with multiple chronic conditions, Substance Use Disorders and/or Serious Mental Illness.

D. Experience working with entities such as health networks, providers and county agencies and/or community-based organizations.

E. OFFEROR must submit their background check process for their staff for review by CalOptima.

F. Ability to hire, retain, manage and support paraprofessional or other staff with experience and knowledge of the population and processes specific to the designated service type as described below;

   a) If staff have insufficient required experience, please explain how OFFEROR would train staff to provide support services and participate in interdisciplinary care plans.

   b) Ability to provide services within two (2) business days of request.

   c) Ability to support members' need to speak in Orange County threshold languages.

G. Ability to receive, record and disseminate information about encounters with members, including services provided, findings, recommendations, referrals e.g., with member, health plan or other business partnerships involved in the care of members.

H. Confirm the ability to use tools created by CalOptima, to dedicate time for staff to train in use of these tools and to adopt internal processes (e.g., policies, desktops and reports) to track interventions, capture health outcomes, facilitate care planning and referral management.

I. Communication methods proposed to communicate with CalOptima and other contracted entities (such as health networks).

J. Current processes in place to handle urgent and emergent member grievances and coordinate resolutions.

K. Experience in providing accompaniment to appointments or direct face-to-face services to members related to physical health, mental health and/or social determinants of health services.

L. OFFEROR's process/ability to assign the designated staff to accompany the same member to future appointments.

M. How OFFEROR selects staff to accompany member (e.g., geographical, language/culture, type appointment) and, if applicable, how processes will be modified for HHP.

N. How staff currently prepares for an appointment/face-to-face session and what information may be needed from CalOptima.

O. Tools or standards staff will follow to report or document the notes after accompaniment event.

P. Describe OFFEROR's ability to be flexible with contracted entities to provide the same services with various expectations from contracted entities.

RFP Attachment 1: Mandatory Offeror Acknowledgement

ACKNOWLEDGEMENT

In signing this Proposal, Offeror acknowledges receipt of the RFP 19-021A and the following addenda, if any (expand list as necessary):

Addendum no. _____ , Received on: _____

Addendum no. _____ , Received on: _____

Addendum no. _____ , Received on: _____

I acknowledge receipt of RFP 19-021A and addenda cited.

I hereby certify on behalf of _____ that the contents of this Proposal are, to the best of my ability, completely in compliance with all requirements of the RFP 19-021A and the terms and conditions of the contract, without exceptions, other than those expressly listed and explained in this Proposal. This Proposal is an irrevocable offer, which shall remain in full force and effect for 150 calendar days after the Proposal due date.

Company Name: _____

Address: _____

Telephone Number: _____

Signature Of Person Authorized To Bind Offeror: _____

Signatory's Name And Title: _____

Date Signed: _____

RFP Attachment 2: Mandatory Non-Collusion Affidavit

NON-COLLUSION AFFIDAVIT

_____, being first duly sworn, deposes and says that he or she is_____ of _____ the party making the foregoing Proposal that the Proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the Proposal is genuine and not collusive or sham; that the Offeror has not directly or indirectly induced or solicited any other Offeror to put in a false or sham Proposal and has not directly or indirectly colluded, conspired, connived, or agreed with any Offeror or anyone else to put in a sham Proposal, or that anyone shall refrain from bidding; that the Offeror has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the Proposal price of the Offeror or any other Offeror or to fix any overhead, profit, or cost element of the Proposal price, or of that of any other Offeror, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the Proposal are true; and, further, that the Offeror has not, directly or indirectly, submitted his or her Proposal price or any breakdown thereof, or the contents thereof, or divulged information or date relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, bid depository, or to any member or agent thereof to effectuate a collusive or sham bid.

_____ _____

Signature Date

_____

Title

RFP Attachment 3: Offeror Eligibility Certification

OFFEROR ELIGIBILITY CERTIFICATION

Offeror certifies, to the best of its knowledge and belief, that that offeror and/or any of its Principals:

A. Are ☐, are not ☐ presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contract by any Federal agency or from participating in any Federal healthcare programs;

B. Have ☐, have not ☐, within a ten (10)-year period preceding this offer, been convicted of or had a civil judgement rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) contract or subcontract; violation of Federal or State antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violating Federal criminal tax laws, or receiving stolen property;

C. Are ☐, are not ☐ presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in Section (B); and

D. Have ☐, have not ☐, within a ten (10)-year period preceding this offer, been notified of any delinquent Federal taxes in an amount that exceeds $3,000 for which the liability remains unsatisfied.

For purposed of this certification, "Principal" means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g. general manager, plant manager, head of a division or business segment and similar positions).

By:
Name: _____
Title: _____
Company: _____
Date: _____

Revised February 2019

RFP Attachment 4: CalOptima Sample Contract and Sample BAA

Click on icon below for Attachment 4.


19-021A - Non-Medical Ancilla


19-021 - HHP Select Services - Sample BA

RFP Attachment 5: Request to Negotiate Contract/BAA Terms

Click on icon below for Attachment 5.

Request to
Negotiate Contract T

RFP Attachment 6: Security Questionnaire

Offeror is required to certify that it (and any proposed subcontractors) comply with the following security provisions, as required in this RFP. Offeror must complete the following questionnaire and explain how you propose to meet any exceptions.

1. Information Security Program, Policy & Procedures

    a. Do you have documented information security policies and procedures? If so, list the titles of each policy.

    b. Does your security policy meet HIPAA requirements? Has it been audited by external auditor, and if so, when was it last audited?

    c. Do you have a formal information classification procedure? Describe in particular, how would patient data be categorized?

2. Personnel Security

    a. Has your organization formally appointed a central point of contact for security coordination, e.g. a designated information security officer and/or privacy officer? If so, whom, and what is their position within the organization?

    b. Does your organization perform background checks to examine and access an employees' or contractor's work and criminal history?

    c. Do you work with third parties, such as IT service providers that have access to or store your sensitive information?

    d. In the event of a security incident with one of your third-party vendors, what is the policy for alert notifications, timeline for resolution, etc? If such a process exists, provide the document as part of your response as Proposal Exhibit: Third-party Security Event Notices

3. Network Security

    a. Provide a diagram of your firms network configuration. Has your IT vendor provided information regarding how your sensitive information systems are protected?

    b. Are systems and networks that host, process and or transfer sensitive information "protected" (isolated or separated) from other systems and/or networks?

    c. Are internal and external networks separated by firewalls with access policies and rules?

    d. Is there a standard approach for protecting network devices to prevent unauthorized access/network related attacks and data-theft?

    e. Is sensitive information transferred to external recipients? If so, what controls are in place to protect sensitive information when transferred (e.g. with encryption?)

    f. How does your firm manage vulnerabilities and threats? How often are Vulnerability Assessments performed?

g. What is the remediation process for vulnerabilities that are discovered?

h. Are third party connections to your network monitored and reviewed to confirm authorized access and appropriate usage? How often does your firm attest third party network connectivity?

i. What network security tools do you have in place? (i.e., DLP, IPS/IDS, Advanced Malware Detection, Web Content Filtering, etc.).

j. Describe your methodology for tuning your security tools (i.e., DLP, IPS, Advanced Malware Detection, Web Content Filtering, etc.) How do you ensure your security tools are effective and up to date?

k. Does your firm conduct annual internal and external penetration tests by a 3rd party?

4. Logical Access

a. Do you have a formal access authorization process based on "least privilege" (employees are granted the least amount of access possible in order to perform their assigned duties) and need to know (access permissions are granted based upon the legitimate business need of the user to access the information)?

b. How are systems and applications configured to allow access only to authorized individuals?

c. Is there a list maintained of authorized users with access (administrative access) to operating systems?

d. Does your firms system support mobile devices? If so, describe in detail how your firm can control mobile device access.

e. Is sensitive information (e.g. social security numbers) masked or removed from, or encrypted within, documents and or websites before it is distributed?

f. Is software installation restricted for desktops, laptops and servers? What type of system hardening does your firm perform?

g. Is access to source application code restricted? If so, how? Is a list of authorized user maintained? How does your firm protect its source code?

h. Are user IDs for your system uniquely identifiable?

i. Do you have a process to review user accounts and related access? How does your firm do user attestation?

5. Operations Management

a. Has antivirus software been deployed and installed on your computers and supporting systems (e.g., desktops, servers and gateways?)

b. Are systems and networks monitored for security events? If so, describe monitoring in detail.

c. Do procedures exist to protect documents, computer media (e.g., tapes, disks, CD-ROMs, etc.) from unauthorized disclosure, modification, removal, and destruction? Is sensitive data encrypted when stored on laptop, desktop and server hard drives, flash drives, backup tapes, etc.?

d. Does your firm send backup tapes to an offsite vendor? If so, name the vendor.

e. Are there security procedures for the decommissioning (replacement) of IT equipment and IT storage devices which contain or process sensitive information? If so, please describe.

f. Are development, test and production environments separated from operational IT environments to protect production (actively used) applications from inadvertent changes or disruption?

g. Are duties separated, where appropriate, to reduce the opportunity for unauthorized modification, unintentional modification or misuse of the organization's IT assets?

h. Do formal change management procedures exist for networks, systems, desktops, software releases, deployments, and software vulnerability (e.g., Virus or Spyware) patching activities?

6. Incident Management and Investigations

a. Is a formalized and documented process in place for incidents and investigations?

b. How do you identify, respond to and mitigate suspected or known security incidents?

c. During the investigation of a security incident, is evidence properly collected and maintained?

d. Are incidents identified, investigated, and reported according to applicable legal requirements?

e. How are incidents escalated and communicated?

RFP Attachment 7: Campaign Contribution Disclosure

CALOPTIMA LEVINE ACT DISCLOSURE STATEMENT

California Government Code section 84308, commonly referred to as the "Levine Act," precludes an Officer of a local government agency from participating in the award of a contract if he or she receives any political contributions totaling more than $250 in the 12 months preceding the pendency of the contract award, and for three months following the final decision, from the person or company awarded the contract. This prohibition applies to contributions to the Officer, or received by the Officer on behalf of any other Officer, or on behalf of any candidate for office or on behalf of any committee. The Levine Act also requires disclosure of such contributions by a party to be awarded a specified contract. Please refer to Attachment A to this Statement for the complete statutory language.

Current members of the CalOptima Board of Directors are:

Ria Berger	Ron DiLuigi	Andrew Do	Dr. Nikan Khatibi
Alexander Nguyen, M.D.	Lee Penrose	Richard Sanchez	J. Scott Schoeffel
Michelle Steel	Paul Yost, M.D.	Doug Chaffee (Alternate)	

1. Have you or your company, or any agent on behalf of you or your company, made any political contributions of more than $250 to any CalOptima Director(s) in the 12 months preceding the date of the issuance of this request for proposal or request for qualifications?

___ YES ___ NO

If yes, please identify the Director(s):

2. Do you or your company, or any agency on behalf of you or your company, anticipate or plan to make any political contributions of more than $250 to any CalOptima Director(s) between the date of issuance of this request for proposals and the award of the contract, or in the three months following the award of the contract?

___ YES ___ NO

If yes, please identify the Director(s):

Answering yes to either of the two questions above does not preclude CalOptima from awarding a contract to your firm. It does, however, preclude the identified Director(s) from participating in the contract award process for this contract.

_____ _____

DATE (SIGNATURE OF AUTHORIZED OFFICIAL)

_____

(TYPE OR WRITE APPROPRIATE NAME, TITLE)

_____

(TYPE OR WRITE NAME OF COMPANY)

CALOPTIMA LEVINE ACT DISCLOSURE STATEMENT
Attachment A

California Government Code Section 84308

(a) The definitions set forth in this subdivision shall govern the interpretation of this section.

(1) "Party" means any person who files an application for, or is the subject of, a proceeding involving a license, permit, or other entitlement for use.

(2) "Participant" means any person who is not a party but who actively supports or opposes a particular decision in a proceeding involving a license, permit, or other entitlement for use and who has a financial interest in the decision, as described in Article 1 (commencing with Section 87100) of Chapter 7. A person actively supports or opposes a particular decision in a proceeding if he or she lobbies in person the officers or employees of the agency, testifies in person before the agency, or otherwise acts to influence officers of the agency.

(3) "Agency" means an agency as defined in Section 82003 except that it does not include the courts or any agency in the judicial branch of government, local governmental agencies whose members are directly elected by the voters, the Legislature, the Board of Equalization, or constitutional officers. However, this section applies to any person who is a member of an exempted agency but is acting as a voting member of another agency.

(4) "Officer" means any elected or appointed officer of an agency, any alternate to an elected or appointed officer of an agency, and any candidate for elective office in an agency.

(5) "License, permit, or other entitlement for use" means all business, professional, trade and land use licenses and permits and all other entitlements for use, including all entitlements for land use, all contracts (other than competitively bid, labor, or personal employment contracts), and all franchises.

(6) "Contribution" includes contributions to candidates and committees in federal, state, or local elections.

(b) No officer of an agency shall accept, solicit, or direct a contribution of more than two hundred fifty dollars ($250) from any party, or his or her agent, or from any participant, or his or her agent, while a proceeding involving a license, permit, or other entitlement for use is pending before the agency and for three months following the date a final decision is rendered in the proceeding if the officer knows or has reason to know that the participant has a financial interest, as that term is used in Article 1 (commencing with Section 87100) of Chapter 7. This prohibition shall apply regardless of whether the

officer accepts, solicits, or directs the contribution for himself or herself, or on behalf of any other officer, or on behalf of any candidate for office or on behalf of any committee.

(c) Prior to rendering any decision in a proceeding involving a license, permit or other entitlement for use pending before an agency, each officer of the agency who received a contribution within the preceding 12 months in an amount of more than two hundred fifty dollars ($250) from a party or from any participant shall disclose that fact on the record of the proceeding. No officer of an agency shall make, participate in making, or in any way attempt to use his or her official position to influence the decision in a proceeding involving a license, permit, or other entitlement for use pending before the agency if the officer has willfully or knowingly received a contribution in an amount of more than two hundred fifty dollars ($250) within the preceding 12 months from a party or his or her agent, or from any participant, or his or her agent if the officer knows or has reason to know that the participant has a financial interest in the decision, as that term is described with respect to public officials in Article 1 (commencing with Section 87100) of Chapter 7.

If an officer receives a contribution which would otherwise require disqualification under this section, returns the contribution within 30 days from the time he or she knows, or should have known, about the contribution and the proceeding involving a license, permit, or other entitlement for use, he or she shall be permitted to participate in the proceeding.

(d) A party to a proceeding before an agency involving a license, permit, or other entitlement for use shall disclose on the record of the proceeding any contribution in an amount of more than two hundred fifty dollars ($250) made within the preceding 12 months by the party, or his or her agent, to any officer of the agency. No party, or his or her agent, to a proceeding involving a license, permit, or other entitlement for use pending before any agency and no participant, or his or her agent, in the proceeding shall make a contribution of more than two hundred fifty dollars ($250) to any officer of that agency during the proceeding and for three months following the date a final decision is rendered by the agency in the proceeding. When a closed corporation is a party to, or a participant in, a proceeding involving a license, permit, or other entitlement for use pending before an agency, the majority shareholder is subject to the disclosure and prohibition requirements specified in subdivisions (b), (c), and this subdivision.

(e) Nothing in this section shall be construed to imply that any contribution subject to being reported under this title shall not be so reported.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

Background

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

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with staff's understanding as presented in this document or if it includes significant unexpected language changes, staff will return to the Board of Directors for consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM

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

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

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

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

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014

A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

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

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

23. Consider Adoption of Resolution Approving Revised CalOptima 2021 Compliance Plan and Authorizing the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures.

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Silver Ho, Compliance Officer, (657) 235-6997

Recommended Actions

1. Adopt Resolution No. 20-1203-03, Approving Revised CalOptima 2021 Compliance Plan; and
2. Authorize the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures.

Background

CalOptima is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations, and rules, including those pertaining to its Federal and State health care program requirements. As part of that commitment, on December 5, 2019, the CalOptima Board of Directors reviewed and approved the updated Compliance Plan, which includes the Code of Conduct, and the Fraud, Waste, and Abuse (FWA) Plan. The Compliance Plan comprehensively addresses the fundamental elements necessary for an effective Compliance Program, including those elements identified by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS).

Discussion

CalOptima regularly reviews the Compliance Plan to ensure it is up-to-date and aligned with Federal and State health care program requirements and laws as well as CalOptima operations. CalOptima's Executive Director of Compliance (Compliance Officer) has reviewed the Compliance Plan and Office of Compliance Policies and Procedures to ensure consistency with applicable Federal and State health care program laws, regulations, and guidance.

Compliance Program Elements

Federal laws and regulations (including the federal U.S. Sentencing Guidelines, and CMS Medicare Advantage regulations) and the OIG compliance guidance require that Compliance Programs be reasonably designed, implemented, and enforced, to ensure the Compliance Program is effective in preventing and detecting violations of standards or law. CalOptima's Compliance Program addresses each of the seven (7) fundamental elements of an effective Compliance Program, in addition to FWA detection, prevention, and remediation.

Written Standards

As part of the Compliance Program, CalOptima develops, maintains, and distributes to its Board Members, Employees, and First Tier, Downstream or Related Entities (FDRs) written standards in the form of the Compliance Plan, a Code of Conduct, and written Policies and Procedures, as further

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detailed in the Compliance Plan. The Compliance Plan incorporates all the elements of an effective Compliance Program as recommended by the OIG and required by CMS regulations. The Compliance Plan also incorporates a comprehensive FWA section, which establishes guidelines and procedures designed to detect, prevent, and remediate FWA in CalOptima Programs.

Oversight
The CalOptima Board of Directors (the "Board"), the governing body of CalOptima, is responsible for ensuring and overseeing the implementation, effectiveness, and continued operation of the Compliance Program. The Board delegates to the CEO, who then delegates to the Compliance Officer, a CalOptima Employee, the administration of the Compliance Program's development, maintenance, implementation, monitoring, and enforcement activities. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in the Compliance Plan. The Audit & Oversight Committee (AOC), a subcommittee of the Compliance Committee, is responsible for overseeing the internal business and delegated activities.

Training and Education
Utilizing web-based training courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and educational courses governing CalOptima's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles, or positions, within, or with, CalOptima's departments and its programs. CalOptima Board Members, Employees, and FDRs receive copies of CalOptima's Code of Conduct and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), and Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, upon appointment, hire, or commencement of a contract, as applicable, and annually thereafter.

Effective Lines of Communication and Reporting
CalOptima utilizes various methods to communicate general information, regulatory updates, and process changes from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and members, including, but not limited to, presentations at meetings and updates in print and/or electronic form, including information on how to identify, report, and prevent compliance issues and FWA. CalOptima Board Members, Employees, FDRs, and/or Members receive information and reminders to report compliance concerns, questionable conduct or practices, and suspected, or actual, non-compliance issues, or FWA incidents, through one of CalOptima's multiple reporting mechanisms. These reporting options, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima maintains and supports a no retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Enforcement and Disciplinary Standards
Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima's standards, requirements, or applicable laws as specified in the Compliance Program documents and related Policies and Procedures, including, but not limited to, CalOptima's policies on Performance and Behavior Standards, Corrective Action Plans, and/or Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented

when non-compliance, or unethical behavior, is determined, and appropriate disciplinary action is implemented to address improper conduct, activity, and/or behavior.

Monitoring, Auditing, and Identification of Risks
CalOptima has implemented and continues to implement comprehensive monitoring and auditing activities identified through a combination of activities performed by the Audit & Oversight Department in conjunction with CalOptima contract owners, and functional business owners responsible for on-going monitoring. The purpose of CalOptima's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and Federal and State laws, as well as applicable Policies and Procedures established to protect against non-compliance and potential FWA in CalOptima Programs. The Compliance Plan and related Policies and Procedures, address the monitoring and auditing processes that are carried out by CalOptima.

Response and Remediation
Once a violation, or an offense, has been detected or reported, CalOptima initiates all necessary steps to investigate, identify, and respond appropriately to the violation, or offense, and to prevent similar violations and offenses from occurring. As described in the Compliance Plan, CalOptima will conduct a timely and documented investigation, and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and its Policies and Procedures to prevent the same, or similar, violation or offense, from occurring in the future.

Summary of Changes
The Compliance Plan has been updated and revised as follows:

- Clarified the composition of the Compliance Committee;
- Added language to define roles and responsibilities with respect to on-going monitoring and auditing activities;
- Revised language to clarify the Fraud, Waste, and Abuse (FWA) Department's reporting process to align with current procedures;
- Updates to formatting of defined terms; and
- Additions and updates to Glossary terms.

Policies and Procedures
To align with the revised Compliance Plan, and consistent with applicable Federal and State health care program laws, regulations and/or guidance, the Compliance Officer, with the support of the Office of Compliance staff, updated related Policies and Procedures. The summary of changes is included in Attachment 3.

Fiscal Impact
The recommended actions to approve the revised CalOptima 2021 Compliance Plan and revised Office of Compliance policies and procedures have no anticipated fiscal impact. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or in future operating budgets.

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Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt CalOptima's updated 2021 Compliance Plan, and related Policies and Procedures. The updated 2021 Compliance Plan will supersede the prior updated Compliance Plan and Code of Conduct approved on December 5, 2019. Staff also recommends that the Board approve and adopt revised, related Policies and Procedures to implement the updated 2021 Compliance Plan.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 20-1203-03, Resolution Approving CalOptima's Updated 2021 Compliance Plan and Authorize the Board of Directors to approve revised policies and procedures.
2. Draft 2021 Compliance Plan (redlined and clean versions).
3. Summary of Proposed Actions to CalOptima Office of Compliance Policies and Procedures.
4. Revised Office of Compliance Policies and Procedures (redlined and clean versions).

/s/ Richard Sanchez — *11/24/2020*

Authorized Signature — **Date**

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RESOLUTION NUMBER 20-1203-03

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima

APPROVING CALOPTIMA'S UPDATED 2021 COMPLIANCE PLAN

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provides that the Board of Directors is the governing body of CalOptima, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima shall be exercised, its property controlled and its business and affairs conducted by or under the direction of the Board; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations consistent will all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima's commitment to compliant, lawful, and ethical conduct, and values the importance of compliance and ethics in CalOptima's operations; and

WHEREAS, the Board of Directors last reviewed and approved the Compliance Program on December 5, 2019 including the Compliance Plan, Code of Conduct, and related policies and procedures; and

WHEREAS, the Board of Directors reviews the Compliance Program documents on a periodic basis to ensure the Compliance Program is consistent with and updated to reflect applicable laws, regulations, and guidelines and to demonstrate the Board of Director's commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2021 Compliance Plan, including the Fraud, Waste, and Abuse Plan, and the Code of Conduct.

Section 2. The Board of Directors hereby approves and adopts the revised Office of Compliance Policies and Procedures.

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the Compliance Program.

Section 4. These actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima, this 3rd day of December 2020.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

Orange County Health Authority
dba CalOptima

2021~~0~~ Compliance Plan

(Revised December 20~~19~~20)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and other CalOptima Programs.*

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and Monitoring responsibilities related to CalOptima's First Tier, Downstream, and Related Entities (FDRs), such as Health Networks, physician groups, Participating Providers, and Suppliers, Pharmacy Benefit Manager (PBM), and consultants. The term FDR is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). Such persons/entities, referred to as FDR herein, include those that directly contract with CalOptima and those that are Downstream or Related Entities (i.e., subcontracts) with CalOptima's First Tier Entities.

CalOptima has developed a comprehensive Compliance Program applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The Compliance Program incorporates all elements of an effective Compliance Program as recommended by the Office of the Inspector General (OIG) and required by CMS regulations. The Compliance Program is continually evolving and may be modified and enhanced based on compliance Monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima Board Members, Employees, and FDRs conduct themselves in accordance with the requirements of CalOptima's Compliance Program.

B. THE COMPLIANCE PLAN

This Compliance Plan sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently Monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective Compliance Program and identifies how CalOptima is implementing each of the fundamental elements of an effective Compliance Program in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the Compliance Plan is designed to provide guidance and to ensure that CalOptima's operations and the practices of its Board Members, Employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted by the Governing Body. It was developed and is managed by the Executive Director of Compliance (hereinafter referred to as the "Compliance Officer") with the Compliance Committee. Due to the dynamic nature of the complex laws governing CalOptima and its programs, the Compliance Plan may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, Employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related Policies and Procedures, as may be amended. Furthermore, Board Members, Employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a Board Member, Employee, and/or FDR has/have any questions about the application, or implementation, of this Compliance Plan, or questions related to the Code of Conduct or CalOptima Policies and Procedures, he or she should seek guidance from the Compliance Officer and/or the CalOptima Office of Compliance.

I. WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Board Members, Employees, and FDRs, CalOptima develops, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written Policies and Procedures.

a. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima Board Members, Employees, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima's commitment to preventing Fraud, Waste, & Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Programs. The Compliance Plan is available on CalOptima's external website for Board Members and FDRs, as well as on CalOptima's ~~internal~~ intranet site, referred to as InfoNet, accessible to all Employees.

b. Policies and Procedures

CalOptima also developed written Policies and Procedures to address specific areas of CalOptima's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima can efficiently Monitor adherence to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, Employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, Employees, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer, or his/her Designee, will ensure that Board Members, Employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

The Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's Policies and Procedures are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key Management staff, meets regularly to review and approve proposed changes and additions to CalOptima's Policies and Procedures. Policies and Procedures are available on CalOptima's internal website and Compliance 360 (C360), a separate web portal accessible to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum.

c. Code of Conduct

Finally, the Code of Conduct is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the Code of Conduct is to articulate compliance expectations and broad principles that guide CalOptima Board Members, Employees, and FDRs in conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is a separate document from the Compliance Plan and can be found in Appendix A. The Code of Conduct is approved by the CalOptima Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by the CalOptima Board, the Compliance Officer, the Compliance Committee, the Audit & Oversight Committee, and Executive Staff.

a. Governing Body

The CalOptima Board of Directors, as the Governing Body, is responsible for approving, implementing, and Monitoring a Compliance Program governing CalOptima's operations. The CalOptima Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an Employee of CalOptima, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CalOptima Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

To ensure the CalOptima Board exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's Compliance Program, the CalOptima Board:

- Understands the content and operation of CalOptima's Compliance Program;
- Approves the Compliance Program, including this Compliance Plan and the Code of Conduct;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the Compliance Program outcomes, including, but not limited to, results of internal and external Audits;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the Compliance Program;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, Corrective Action Plans, Warning Letters, and/or Sanctions;
- Receives regularly scheduled, periodic updates from CalOptima's Compliance Officer and Compliance Committee, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the Compliance Program.

The CalOptima Board reviews the measurable indicators of an effective Compliance Program and remains appropriately engaged in overseeing its efficient and successful implementation; however, the CalOptima Board delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The Executive Director of Compliance serves as the Compliance Officer who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and Monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the CalOptima Board at any time. Furthermore, the Compliance Officer ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the CalOptima Board, CEO, CalOptima's Executive Staff and departmental Management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, FDR and internal oversight, Policies and Procedures, and training on compliance activities.

The CalOptima Board delegates the following responsibilities to the Compliance Officer, and/or his/her Designee(s):

- Chair the Compliance Committee, which shall meet no less than quarterly and assists the Compliance Officer in fulfilling his/her responsibilities;
- Ensure that the Compliance Program, including this Compliance Plan and Policies and Procedures, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected Board Members, Employees, and FDRs, as appropriate;
- Oversee and Monitor the implementation of the Compliance Program, and provide regular reports no less than quarterly to the CalOptima Board and CEO summarizing all efforts, including, but not limited to, the Compliance Committee's efforts to ensure adherence to the Compliance Program, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and Audit activities;
- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential FWA received from any source through any reporting method;

- Design, coordinate, and/or conduct regular internal Audits to ensure the Compliance Program is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of Compliance Program activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board committee and/or to the Board of Directors;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or FWA issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and Monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., DHCS and CMS) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the CalOptima Board, Employees, and FDRs are knowledgeable about CalOptima's Compliance Program, including the Code of Conduct, Policies and Procedures, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate Corrective Action Plans, Sanctions, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and FDRs to ensure Exclusion and Preclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), Medi-Cal Suspended & Ineligible (S&I) Provider List, and the CMS Preclusion List) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of CalOptima's Executive Staff ~~and operational staff~~, as designated by the CEO. The members of the Compliance Committee serve at the discretion of the CEO and may be removed, or added, at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The CalOptima Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Board;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges);

- Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program;
- Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal, and contractual requirements;
- Recommend and Monitor the development of internal systems and controls to implement CalOptima's standards and Policies and Procedures as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of Monitoring and Auditing of areas in which CalOptima is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its FDRs conduct activities and operations in compliance with the applicable laws and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors.

d. Audit & Oversight Committee (AOC)

The Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is co-led by the Director(s) of Audit & Oversight. The AOC is responsible for overseeing the delegated and internal activities of CalOptima. The Compliance Committee has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the AOC may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the AOC are approved by the majority of a quorum of the AOC. A quorum is defined as one (1) over fifty percent (50%). AOC may approve and/or implement Corrective Action Plans (CAPs); however, recommendations for FDR Sanctions and/or de-Delegation are submitted to the Compliance Committee for final approval. The AOC also contributes to external reviews and accreditation Audits, such as the National Committee for Quality Assurance (NCQA).

Responsibilities of the Audit & Oversight Committee with regard to FDRs include:

- Annual review, revision, and approval of the Audit tools;
- Review findings of the Readiness Assessment to evaluate a potential FDR's ability to perform the delegated function(s);
- Review and approve potential FDR entities for Delegation of functions;
- Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and Monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite Audit;
- Ensure all Downstream and Related Entities are Monitored in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues;
- Propose Sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of Delegation, to the Compliance Committee for unresolved issues of compliance.

Responsibilities of the Audit & Oversight Committee regarding internal business functions include:

- Annual review, revision, and approval of the Audit work plan and Audit tools;
- Conduct formal, ongoing evaluation and Monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing Monitoring, and findings of the annual Audit;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues.
- Initiate and manage other disciplinary actions (e.g., Sanctions, de-delegation) for compliance issues.

e. Executive Staff

The CEO and Executive Staff of CalOptima shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective Compliance Program;
- Receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including

Audit findings, Notices of Non-Compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III.TRAINING

Education and training are critical elements of the Compliance Program. CalOptima requires that all Board Members, Employees, and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's Code of Conduct, compliance obligations, relevant laws, and FWA, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the Compliance Program, and which courses are updated regularly to ensure that Employees are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The Compliance Officer, or his/her Designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the CalOptima Executive Staff and Management are responsible for ensuring that Board Members, Employees, and FDRs complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires Board Members, Employees, and FDRs, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the

Compliance Program are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or FWA issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's HIPAA privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure Members' Protected Health Information (PHI) and Personally Identifiable Information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some FDRs may be exempt or deemed to have met the FWA training and education requirement if the FDR has met the CMS requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program. These training opportunities are available to Managers and Employees depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing Managers the tools and resources to train and share the information with Employees in their respective departments. If additional training related to FWA is required, the Compliance Officer, or his/her Designee, will develop relevant materials.

Employees have access through CalOptima's ~~internal~~ intranet website (referred to as the "InfoNet") to CalOptima's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board Members receive a copy of the Compliance Plan, Code of Conduct, and Policies and Procedures pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the CalOptima Board. Board Members may receive additional compliance training related to the CalOptima Board's role in overseeing and ensuring organizational compliance with CalOptima's Compliance Program.

The Code of Conduct and Policies and Procedures pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their Employees, agents, and/or Downstream Entities. CalOptima may also develop compliance training and education presentations and/or roundtables for specified FDRs.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to Policies and Procedures, contact information for the Compliance Officer, relevant federal and state Fraud alerts and policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and Members, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the CalOptima Board, FDRs, Employees, and individual CalOptima departments, and Members.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to Board Members, Employees, and FDRs, which contains CalOptima's updated Policies and Procedures.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to Board Members, Employees, FDRs, and Members.
- Electronic Mail – The CEO, Compliance Officer, or their respective Designee, periodically sends out email communications and/or alerts to Board Members, Employees, and FDRs, and/or Members, as applicable.
- CalOptima's ~~Internal~~ Intranet Website – CalOptima maintains an ~~internal~~ intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to Employees.
- CalOptima's Compliance ~~Internal Website~~Intranet Webpage – The Office of Compliance maintains an internal department ~~website~~ webpage accessible to CalOptima Employees ~~to~~ for ~~communicate~~ communication of different Compliance initiatives, notices, key documents and forms, ~~and~~ updates to the Compliance Program, Code of Conduct, and/or Policies and Procedures.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and FWA throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima Employees.
- Written Reports – The Compliance Officer, in coordination with the CEO and Compliance Committee, prepares written reports, no less than quarterly, concerning the status of the Compliance Program to be presented to the CalOptima Board.
- Direct Contact with the Compliance Officer - Board Members, Employees, and FDRs can obtain additional compliance information directly from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

b. Reporting Mechanisms

CalOptima Board Members, Employees, and FDRs have an affirmative duty and are directed in CalOptima's Code of Conduct and Policies and Procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by Board Members, Employees, and/or FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an FDR contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or FWA incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and FWA issues are also provided to Board Members, Employees, FDRs, and Members in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Upon receipt of a report through one (1) of the listed mechanisms, the Compliance Officer, or his/her Designee, shall follow appropriate Policies and Procedures to promptly review, investigate, and resolve such matters. The Compliance Officer, or his/her Designee, shall Monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to Management or Executive Staff*

CalOptima Employees are encouraged to contact their immediate Management or Executive Staff when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. Executive Staff or Management will promptly escalate the report to the Compliance Officer for further investigation and reporting to the CalOptima Compliance Committee. If an Employee is concerned that his/her Management or Executive Staff did not adequately address his/her report or complaint, the Employee may go directly to the Compliance Officer, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with multilingual support, in which CalOptima may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or FWA issues. The

Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all Board Members, Employees, FDRs, and Members. Members also have access to the Compliance Officer through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline (1-800-447-8477) directly.

3. *Report Directly to the Compliance Officer*

The Compliance Officer is available to receive reports of suspected or actual compliance violations, or FWA issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and Members. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected Fraud and Abuse to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and Members. CalOptima's non-retaliation policy is communicated along with reporting instructions by

posting information on the CalOptima InfoNet and website, as well as sending periodic Member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other Corrective Action Plans for violations, as appropriate, with the approval of the Compliance Committee.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, Employees, and FDRs are provided copies of CalOptima's Code of Conduct and the Compliance Plan and have access on CalOptima's internal and external website to applicable Policies and Procedures, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing Corrective Action Plans and Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. Board Members, Employees, and FDRs may be disciplined or Ssanctioned, as applicable, for failing to adhere to CalOptima's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts; or
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima's HIPAA privacy and security policies, including actions that harm the privacy of Members, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions.
Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, Sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, Employees are subject to discipline, up to and including termination, and FDRs may be Ssanctioned, or contracts may be terminated, where permitted.

Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative Sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Employees shall be evaluated annually based on their compliance with CalOptima's Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with Monitoring and Auditing are identified through a combination of activities performed by the Audit & Oversight Department in conjunction with CalOptima contract owners, and functional business owners responsible for on-going monitoring that is performed, risk assessments, Audit & Oversight Committee and Compliance Committee discussions and decisions, and internal and external reporting. Through Monitoring, Auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The Compliance Officer, or his/her Designee, will collaborate with the Compliance Committee to identify areas of focus for Monitoring and Auditing potential non-compliant activity and FWA issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of FDRs. Operations and processes will be evaluated based on: (1) deficiencies found by Regulatory Agencies; (2) deficiencies found by internal and external Audit and Monitoring reports; (3) the institution of new or updated Policies and Procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by CMS and the OIG Work Plan shall be used as resources to evaluate operational risks.

The Compliance Officer, or his/her Designee, will work with the Chief Operating Officer, or his/her Designee, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring M~~m~~onitoring and Auditing. Those operational areas determined to be high risk may be subject to more frequent Monitoring and Auditing, as well as additional reporting requirements. The risk assessment process will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC, and subsequently to the Compliance Committee, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused Audits may be scheduled based on the results of the ongoing M~~m~~onitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine Auditing and Monitoring Activities to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Policies and Procedures to protect against non-compliance and potential FWA in CalOptima Programs. CalOptima and FDRs shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. Monitoring Activities are regular reviews performed as part of normal operations to

confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An Audit is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a set of standards (e.g., Policies and Procedures, laws, and regulations) used as base measures. As part of the Monitoring process, CalOptima has created a dashboard, which is a Monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with Monitoring operations and outcomes and to identify areas in need of targeted Auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop Monitoring and Auditing work plans. Monitoring and Auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The Monitoring and Auditing work plans are subject to daily updates and additions, and are therefore, working documents. The Compliance Officer, or his/her Designee, in collaboration with the AOC and Compliance Committee, develops the Monitoring and Auditing work plans to address the risks associated with each of CalOptima's Programs.

The Compliance Officer, or his/her Designee, will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate Auditing and Monitoring Activities. Audits for each operational area will be conducted throughout the year consistent with the Monitoring and Auditing work plans. The Compliance Officer, or his/her Designee, will coordinate the Audits with internal audit staff, and, in some cases, with the assistance from an outside vendor. Audit methodologies shall be consistent with regulatory and NCQA requirements and standards. All Audits will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the Audit review is completed, the Audit & Oversight teams will communicate the results to the Compliance Officer and propose follow up corrective action(s), if necessary. The Compliance Officer, or his/her Designee, will provide reports to the CEO and the Compliance Committee concerning the results of the Audits. The AOC reports to the Compliance Officer and the Compliance Committee on Audits that involve FDRs as discussed below. If FWA issues are identified during an Audit, the matter will be further investigated and resolved in a timely manner. In addition, an Audit of the Compliance Program and its effectiveness should occur at least annually, and the results shall be reported to the CalOptima Board.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight Monitoring and Auditing process of FDRs who perform delegated activities. The processes that CalOptima implements to oversee, Monitor, and Audit FDRs are incorporated into CalOptima's written Policies and Procedures, including processes involving R~~r~~eadiness A~~a~~ssessments ~~pre-contractual evaluations~~ and Audits of First Tier Entities. CalOptima may implement Corrective Action Plans, Sanctions, and/or revoke its Delegation of duties (in a manner

permitted under the contract) if CalOptima determines that an FDR is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The Compliance Officer, or his/her Designee, determines the process for Monitoring delegated FDRs and develops the annual Monitoring and Audit calendar in order to validate compliance with contractual standards and regulatory requirements. The AOC is responsible for overseeing all of the delegated activities and will review the Readiness Assessment, ensure the annual review of FDRs for delegated functions are completed, conduct formal on-going evaluation of FDR performance and compliance, ensure Downstream and Related Entities are M~~m~~onitored, and impose Corrective Action Plans and/or Sanctions if the FDR's performance fails to meet statutory and contractual standards and requirements. The AOC may recommend termination of Delegation to the Compliance Committee for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or Delegation agreement with a potential FDR, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's Policies and Procedures, is completed to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, CMS, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not Precluded on the Preclusion List, excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the Medi-Cal Suspended & Ineligible (S&I) Provider List from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the AOC and subsequently the Compliance Committee for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the Delegation agreement specifies the activities CalOptima delegates to the FDRs, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and Audits, and remedies, including disciplinary actions, available to CalOptima. Prior to any Sub-delegation to any Downstream or Related Entity, a First Tier Entity must obtain approval from CalOptima. CalOptima determines who will directly M~~m~~onitor the Downstream or Related Entity's compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements

intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the FDR and their contractually delegated area(s). Furthermore, FDRs will be required to complete, sign, and return attestation forms confirming the FDR's compliance with new hire and annual training and education requirements, which includes courses on general compliance and FWA as well as Exclusion and Preclusion screening and FWA reporting obligations.

3. *Annual Risk Assessment*

The Compliance Officer, or his/her Designee, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (FDR) to determine the FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk, or vulnerable, is presented to the AOC for suggested follow-up Audit. FDRs determined to be high risk may be subjected to a more frequent Monitoring and Auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC and subsequently to the Compliance Committee for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the FDR's ability to provide delegated services in accordance with contractual standards and applicable state, CMS, and accreditation requirements, as further detailed in CalOptima's Policies and Procedures. CalOptima may conduct Audits of FDRs at any time. Such Audits may include an evaluation of the FDR's training and education program and materials covering general compliance and FWA, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk FDRs, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual Audit calendar; however, CalOptima does not limit its Auditing schedule to only high-risk FDRs.

If CalOptima has reason to believe the FDR's ability to perform a delegated function is compromised, an additional focused Audit may be performed. The Compliance Officer, or his/her Designee, may also recommend focused Audits upon evaluation of non-compliant trends or reported incidents. The results of these Audits will be reported to the AOC and then to the Compliance Committee.

A focused Audit may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- ► Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- ► Failure to comply with a Corrective Action Plan;
- ► Reported or alleged Fraud, Waste, and/or Abuse;
- ► Significant policy variations that deviate from the CalOptima or state, CMS, or accreditation requirements;
- ► Bankruptcy, or impending bankruptcy, which may impact services to Members (either suspected or reported);
- ► Sale, merger, or acquisition involving the FDR;
- ► Significant changes in the management of the FDR; and/or
- ► Changes in resources which impact CalOptima's and/or the FDR's operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The Compliance Officer, or his/her Designee, shall submit regular reports of all Mmonitoring, Audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a Corrective Action Plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or his/her Designee. Every Corrective Action Plan is presented to the AOC, in aggregate, with no less than quarterly updates, and recommendations for escalation, as applicable. Supplemental and focused Audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement Sanctions or require remediation by an FDR for failure to fulfill contractual obligations including development and implementation of a Corrective Action Plan. Failure to cooperate with CalOptima in any manner may result in termination of the Delegation agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's Auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the Auditing processes, including Policies and Procedures, Audit tools, and Audit findings, to ensure all regulatory requirements are being Audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- ► The central database of all pending, active, and terminated FDRs to Mmonitor and track functions, performance, and Audit schedules;
- ► Implementation of an escalation process for compliance/performance issues;
- ► Implementation of a process for validation of Audit tools;

- Implementation of a process for noticing FDRs and functional areas of Corrective Action Plans;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding Delegation standards, Auditing, and Monitoring FDR performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of FDR performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight Audits completed within twelve (12) months; and
- Corrective Action Plans (CAPs) completed within the established time frame.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's Policies and Procedures, CalOptima performs Participation Status Reviews by searching the OIG –LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, Employees, and/or FDRs are not excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, Employees, and FDRs are required to disclose their Participation Status as part of their initial appointment, employment, commencement of the contract and registration/application processes and when Board Members, Employees, and FDRs receive notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

The Compliance Officer, or his/her Designee, will review reports from Employees responsible for conducting the Participation Status Reviews to ensure Employees record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the Compliance Officer, or his/her Designee, of affirmative findings of a person, or entity's, failure to meet the Participation Status Review requirements. If CalOptima learns that any prospective, or current, Board Member, Employee, or FDR has been proposed for Exclusion, Excluded or Precluded, CalOptima will promptly remove him/her/the FDR from CalOptima's Programs consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of

their suspension, Exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the CMS Preclusion List, consistent with regulatory guidance, applicable policies, and/or contract terms. The Compliance Officer, or his/her Designee, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII. RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's Compliance Program and/or FWA issues, the Compliance Officer, or his/her Designee, shall, upon promptly verifying the facts related to the violation or likely violation, notify the Compliance Committee, as appropriate. The Compliance Committee (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, Sanctions, termination of any agreement and/or any other corrective action consistent with applicable Policies and Procedures, subject to consultation with legal counsel and/or notifying the Governing Body, as appropriate;
- Implementing education and training programs for Board Members, Employees, and/or FDRs, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's Compliance Plan, Code of Conduct, and/or relevant Policies and Procedures to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the Compliance Officer and the Compliance Committee to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable Policies and Procedures after considering such recommendations. The Compliance Officer, or his/her Designee, may M~~m~~onitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning Fraud schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

activity indicates that Fraud may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a Fraud alert is received, CalOptima shall review its Delegation agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the Delegation agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a Fraud alert. With the issuance of a Fraud alert, CMS places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party need to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged Fraud scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes Member complaints, DHCS Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal and/or State Health Care Programs requirements. CalOptima shall also maintain files that contain documented warnings (e.g., Fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, DHCS, CMS, and CMS' Designee, regarding Monitoring of FDRs within CalOptima's network that DHCS, or CMS, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent FWA within a CalOptima Program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of FWA activity. CalOptima shall assess all FDRs for potential Overpayments when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return Overpayments consistent with applicable laws and regulatory guidance.

As required, CalOptima and/or the FDR shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of Overpayment determinations to Regulatory Agencies, as required by law.

When applicable, CalOptima shall return Overpayments made to CalOptima, consistent with applicable state and federal laws and regulatory guidance.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima's Compliance Program. FWA activities are implemented and overseen by CalOptima's Compliance Officer, or his/her Designee, in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for FWA investigations. The Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Compliance Committee, CEO, the CalOptima Board, and Regulatory Agencies.

CalOptima utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Programs is appropriately delivered to Members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

I.FWA TRAINING

As detailed above, FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. FDRs are also required to complete FWA training, as described above. CalOptima's FWA training provides guidance to Board Members, Employees, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Examples of the most common types of Member FWA (see Appendix B, attached hereto and incorporated herein) and FDR FWA (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Programs (e.g., suspicious activities suggesting CalOptima Members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the CalOptima Programs, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average Member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for FDRs, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima's requirement to train Employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima shall provide Board Members, Employees, FDRs, and Members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with CalOptima internal departments, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of FWA. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. Members, FDRs, Employees, law enforcement and Regulatory Agencies, and others may contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect FWA include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record Audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and Monitoring Activities;
- Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and Audits.

b. Data Analytics

CalOptima uses technology and data analysis to reduce FWA externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect FDRs based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, OneCare Connect, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review

of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or Audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by Members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected FWA. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/ or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will

be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a Member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a Member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the Member/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Compliance Officer, Compliance Committee, and CEO.

III.FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU, or a Designee, interviews the individual who reported the FWA, affected Members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of Member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Compliance Officer and Compliance Committee. If a CalOptima internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused Audits, additional investigation, continued Monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential

FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Policies and Procedures, CalOptima shall take appropriate disciplinary, or corrective, action against Board Members, Employees, and/or FDRs related to validated instances of FWA. CalOptima will also assess FDRs for potential Overpayments when reviewing and undertaking corrective actions. Corrective actions will be Mmonitored by the Compliance Committee, and progressive discipline will be Mmonitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial Sanctions, regulatory reporting, Corrective Action Plans, or termination of the Delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) working days to DHCS after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare, OneCare Connect, or PACE programs.~~case is reported to CalOptima's SIU.~~

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Members; and/or
- Schemes with large financial risk to CalOptima, or its Members.

IV.ANNUAL FWA EVALUATION

CalOptima's Compliance Committee shall periodically review and evaluate the FWA activities and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Compliance Plan, and other input from applicable sources.

a. Retention of Records

CalOptima shall maintain reports and summaries of FWA activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of Member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of FWA investigations in a secure and confidential manner, regardless of the outcome of an investigation.

b. Confidentiality

CalOptima and its FDRs shall maintain all information associated with suspected, or actual, FWA in confidential files, which may only be released in accordance with applicable laws and CalOptima Policies and Procedures. All participants and attendees of CalOptima's Quality Improvement Committee, Compliance Committee, and respective subcommittees shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the Compliance Program, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the Compliance Program against the elements of an effective Compliance Program as recommended by OIG and required by CMS regulations. The following areas will be reviewed:

- Policies and Procedures;
- Compliance Officer and Compliance Committee;
- Training and education of Board Members, Employees, and FDRs;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal Monitoring and Auditing;
- Delegation oversight;
- Exclusion and Preclusion screening process; and
- Prompt responses to detected offenses.

The Compliance Program will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with Executive Staff and Management, the Compliance Committee, and the CalOptima Board. Updates to the Compliance Program will be based on the results of the evaluation and will be referred to the CalOptima Board for review and approval.

I.PRIVILEGED FILES AND DOCUMENT RETENTION

a. Privileged Files

All privileged files shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the Compliance Officer, CalOptima legal counsel, and the Compliance Committee, where appropriate, shall have access to its contents. All materials in the privileged file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. The privileged file shall contain the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the Compliance Officer;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning FDR delegation agreement interpretations and remedies available to CalOptima.

b. Document Retention

CalOptima shall retain contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.604, 606, 608, and 610, for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract (except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

CalOptima shall maintain the documentation required by HIPAA for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) Policies and Procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by HIPAA; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the Fraud, Waste, and Abuse laws. CalOptima is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from

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	relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure

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	effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its Health Networks and third-party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and

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	other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.
Public Integrity CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.

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Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies,

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third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or

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	other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members,	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not

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providers, and other persons is fundamental to fulfilling its mission and goals.	unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will M~~m~~onitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their Exclusion or Preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the

Principle	Standard
	delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a Ssupervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below.

Principle	Standard
	Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by Health Networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

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Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight Audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight Audits.

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FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.
P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight Audit; report by regulatory body; hotline.
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight Audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight Audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

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E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit" or "Auditing") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and may require one (1) of several acknowledged certifications. ~~and normally performed by individuals with one (1) of several acknowledged certifications.~~.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima Members" or "Members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima

under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive Staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees, and FDRs comply with applicable law and ethical standards.

Compliance Risk Assessment ("CRA") A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or Monitoring Activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or **Employees** ("Employee" or "Employees") means any and all employees of CalOptima, including all Executive Staff, Management, officers, managers, Ssupervisors and other employed personnel, as well as temporary employees and volunteers.

Exclusion ("Exclusion" or "Excluded") means suspension, exclusion, or debarment from participation in federal and/or state health care programs.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

Executive Staff ("Executive Staff") means an employee whose position title is Chief, or Executive Director of one (1) or more departments.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State Health Care Programs") means any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a member under a CalOptima program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

General Services Administration ("GSA**"**) **System for Award Management** ("SAM") is a type of federal government exclusion database and contains the list of Excluded Parties List System (GSA-EPLS). The EPLS consists of federal contractors who have been debarred, S~~s~~anctioned, or excluded due to government contract issues or fraud. The database is usually updated on a monthly basis.

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network ("Health Network" or "Health Networks") means the contracted Health Networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health

information, as amended.

Immediate Corrective Action Plan ("ICAP") means the result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Management ("Management") means any employee whose position title is Director, Senior Manager, Manager, or Supervisor of one (1) or more departments.

Medi-Cal Suspended & Ineligible ("S&I") **Provider List** is a list of suspended and ineligible providers that is maintained by DHCS in the Medi-Cal Provider Manual. The list is updated monthly and available online and in print from DHCS.

Medicare Secondary Payer (MSP) Vendor means third-party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare or OneCare Connect for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Multipurpose Senior Services Program ("MSSP") is a program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of Inspector General List of Excluded Individuals and Entities ("OIG LEIE") is an exclusion list and contains individuals and/or entities that have been excluded from participation in federal healthcare programs such as Medicare and Medicaid. This list is usually updated on a monthly basis.

OneCare ("OneCare") is a Medicare Advantage Health Maintenance Organization (HMO) plan offered by CalOptima to provide Medicare covered benefits to Members.

OneCare Connect ("OneCare Connect") is a Medicare-Medicaid health plan offered by CalOptima that contracts with both Medicare and Medi-Cal to provide covered benefits of both programs to Members.

Overpayment ("Overpayment") means a payment disbursed in excess of amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating Providers and Suppliers ("Participating Providers and Suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its Health Networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the Health Networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board Members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Personally Identifiable Information ("PII") means any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmacy Benefit Manager ("PBM") means an entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Program of All-Inclusive Care for the Elderly ("PACE") is a long-term comprehensive health care program that helps older adults to 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.

Preclusion ("Precluded" or "Preclusion List") is a type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Protected Health Information ("PHI") refers to the 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Readiness Assessment ("Readiness Assessment") is an assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CalOptima. The assessment determines the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional area requirements, as determined by CalOptima.

Regulatory Agencies ("Regulatory Agencies") include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

Seniors and Persons with Disabilities ("SPD") means Medi-Cal beneficiaries who fall under specific

Aged and Disabled Aid Codes as defined by the DHCS.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third-Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Orange County Health Authority
dba CalOptima

2021 Compliance Plan

(Revised December 2020)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and other CalOptima Programs.

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and Monitoring responsibilities related to CalOptima's First Tier, Downstream, and Related Entities (FDRs), such as Health Networks, physician groups, Participating Providers, and Suppliers, Pharmacy Benefit Manager (PBM), and consultants. The term FDR is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). Such persons/entities, referred to as FDR herein, include those that directly contract with CalOptima and those that are Downstream or Related Entities (i.e., subcontracts) with CalOptima's First Tier Entities.

CalOptima has developed a comprehensive Compliance Program applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The Compliance Program incorporates all elements of an effective Compliance Program as recommended by the Office of the Inspector General (OIG) and required by CMS regulations. The Compliance Program is continually evolving and may be modified and enhanced based on compliance Monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima Board Members, Employees, and FDRs conduct themselves in accordance with the requirements of CalOptima's Compliance Program.

B. THE COMPLIANCE PLAN

This Compliance Plan sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently Monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective Compliance Program and identifies how CalOptima is implementing each of the fundamental elements of an effective Compliance Program in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the Compliance Plan is designed to provide guidance and to ensure that CalOptima's operations and the practices of its Board Members, Employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted by the Governing Body. It was developed and is managed by the Executive Director of Compliance (hereinafter referred to as the "Compliance Officer") with the Compliance Committee. Due to the dynamic nature of the complex laws governing CalOptima and its programs, the Compliance Plan may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, Employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related Policies and Procedures, as may be amended. Furthermore, Board Members, Employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a Board Member, Employee, and/or FDR has/have any questions about the application, or implementation, of this Compliance Plan, or questions related to the Code of Conduct or CalOptima Policies and Procedures, he or she should seek guidance from the Compliance Officer and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Board Members, Employees, and FDRs, CalOptima develops, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written Policies and Procedures.

a. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima Board Members, Employees, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima's commitment to preventing Fraud, Waste, & Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Programs. The Compliance Plan is available on CalOptima's external website for Board Members and FDRs, as well as on CalOptima's intranet site, referred to as InfoNet, accessible to all Employees.

b. Policies and Procedures

CalOptima also developed written Policies and Procedures to address specific areas of CalOptima's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima can efficiently Monitor adherence to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, Employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, Employees, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer, or his/her Designee, will ensure that Board Members, Employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

The Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's Policies and Procedures are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key Management staff, meets regularly to review and approve proposed changes and additions to CalOptima's Policies and Procedures. Policies and Procedures are available on CalOptima's internal website and Compliance 360 (C360), a separate web portal accessible to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum.

c. Code of Conduct

Finally, the Code of Conduct is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the Code of Conduct is to articulate compliance expectations and broad principles that guide CalOptima Board Members, Employees, and FDRs in conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is a separate document from the Compliance Plan and can be found in Appendix A. The Code of Conduct is approved by the CalOptima Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by the CalOptima Board, the Compliance Officer, the Compliance Committee, the Audit & Oversight Committee, and Executive Staff.

a. Governing Body

The CalOptima Board of Directors, as the Governing Body, is responsible for approving, implementing, and Monitoring a Compliance Program governing CalOptima's operations. The CalOptima Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an Employee of CalOptima, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CalOptima Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

To ensure the CalOptima Board exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's Compliance Program, the CalOptima Board:

- Understands the content and operation of CalOptima's Compliance Program;
- Approves the Compliance Program, including this Compliance Plan and the Code of Conduct;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the Compliance Program outcomes, including, but not limited to, results of internal and external Audits;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the Compliance Program;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, Corrective Action Plans, Warning Letters, and/or Sanctions;
- Receives regularly scheduled, periodic updates from CalOptima's Compliance Officer and Compliance Committee, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the Compliance Program.

The CalOptima Board reviews the measurable indicators of an effective Compliance Program and remains appropriately engaged in overseeing its efficient and successful implementation; however, the CalOptima Board delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The Executive Director of Compliance serves as the Compliance Officer who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and Monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the CalOptima Board at any time. Furthermore, the Compliance Officer ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the CalOptima Board, CEO, CalOptima's Executive Staff and departmental Management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, FDR and internal oversight, Policies and Procedures, and training on compliance activities.

The CalOptima Board delegates the following responsibilities to the Compliance Officer, and/or his/her Designee(s):

- Chair the Compliance Committee, which shall meet no less than quarterly and assists the Compliance Officer in fulfilling his/her responsibilities;
- Ensure that the Compliance Program, including this Compliance Plan and Policies and Procedures, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected Board Members, Employees, and FDRs, as appropriate;
- Oversee and Monitor the implementation of the Compliance Program, and provide regular reports no less than quarterly to the CalOptima Board and CEO summarizing all efforts, including, but not limited to, the Compliance Committee's efforts to ensure adherence to the Compliance Program, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and Audit activities;
- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential FWA received from any source through any reporting method;

- ► Design, coordinate, and/or conduct regular internal Audits to ensure the Compliance Program is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- ► Develop and implement an annual schedule of Compliance Program activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board committee and/or to the Board of Directors;
- ► Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or FWA issues, including facilitating any documentation or procedural requests by such agency(s);
- ► Oversee and Monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., DHCS and CMS) and consult with legal counsel, as necessary;
- ► Create and coordinate educational training programs and initiatives to ensure that the CalOptima Board, Employees, and FDRs are knowledgeable about CalOptima's Compliance Program, including the Code of Conduct, Policies and Procedures, and all current and emerging applicable statutory and regulatory requirements;
- ► Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate Corrective Action Plans, Sanctions, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- ► Coordinate with CalOptima departments and FDRs to ensure Exclusion and Preclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), Medi-Cal Suspended & Ineligible (S&I) Provider List, and the CMS Preclusion List) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of CalOptima's Executive Staff, as designated by the CEO. The members of the Compliance Committee serve at the discretion of the CEO and may be removed, or added, at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The CalOptima Board delegates the following responsibilities to the Compliance Committee:

- ► Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Board;
- ► Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges);

- ► Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- ► Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program;
- ► Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal, and contractual requirements;
- ► Recommend and Monitor the development of internal systems and controls to implement CalOptima's standards and Policies and Procedures as part of its daily operations;
- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
- ► Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- ► Review and address reports of Monitoring and Auditing of areas in which CalOptima is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;
- ► Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its FDRs conduct activities and operations in compliance with the applicable laws and regulations and sound business ethics; and
- ► Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors.

d. Audit & Oversight Committee (AOC)

The Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is co-led by the Director(s) of Audit & Oversight. The AOC is responsible for overseeing the delegated and internal activities of CalOptima. The Compliance Committee has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the AOC may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the AOC are approved by the majority of a quorum of the AOC. A quorum is defined as one (1) over fifty percent (50%). AOC may approve and/or implement Corrective Action Plans (CAPs); however, recommendations for FDR Sanctions and/or de-Delegation are submitted to the Compliance Committee for final approval. The AOC also contributes to external reviews and accreditation Audits, such as the National Committee for Quality Assurance (NCQA).

Responsibilities of the Audit & Oversight Committee with regard to FDRs include:

- ► Annual review, revision, and approval of the Audit tools;
- ► Review findings of the Readiness Assessment to evaluate a potential FDR's ability to perform the delegated function(s);
- ► Review and approve potential FDR entities for Delegation of functions;
- ► Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- ► Conduct formal, ongoing evaluation and Monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite Audit;
- ► Ensure all Downstream and Related Entities are Monitored in accordance with CalOptima oversight procedures;
- ► Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- ► Initiate and manage Corrective Action Plans (CAPs) for compliance issues;
- ► Propose Sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and
- ► Review and initiate recommendations, such as termination of Delegation, to the Compliance Committee for unresolved issues of compliance.

Responsibilities of the Audit & Oversight Committee regarding internal business functions include:

- ► Annual review, revision, and approval of the Audit work plan and Audit tools;
- ► Conduct formal, ongoing evaluation and Monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing Monitoring, and findings of the annual Audit;
- ► Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- ► Initiate and manage Corrective Action Plans (CAPs) for compliance issues.
- ► Initiate and manage other disciplinary actions (e.g., Sanctions, de-delegation) for compliance issues.

e. Executive Staff

The CEO and Executive Staff of CalOptima shall:

- ► Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective Compliance Program;
- ► Receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- ► Be advised of all governmental compliance and enforcement findings and activity, including

Audit findings, Notices of Non-Compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III.TRAINING

Education and training are critical elements of the Compliance Program. CalOptima requires that all Board Members, Employees, and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's Code of Conduct, compliance obligations, relevant laws, and FWA, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the Compliance Program, and which courses are updated regularly to ensure that Employees are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The Compliance Officer, or his/her Designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the CalOptima Executive Staff and Management are responsible for ensuring that Board Members, Employees, and FDRs complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires Board Members, Employees, and FDRs, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the

Compliance Program are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or FWA issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's HIPAA privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure Members' Protected Health Information (PHI) and Personally Identifiable Information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some FDRs may be exempt or deemed to have met the FWA training and education requirement if the FDR has met the CMS requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program. These training opportunities are available to Managers and Employees depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing Managers the tools and resources to train and share the information with Employees in their respective departments. If additional training related to FWA is required, the Compliance Officer, or his/her Designee, will develop relevant materials.

Employees have access through CalOptima's intranet website (referred to as the "InfoNet") to CalOptima's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board Members receive a copy of the Compliance Plan, Code of Conduct, and Policies and Procedures pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the CalOptima Board. Board Members may receive additional compliance training related to the CalOptima Board's role in overseeing and ensuring organizational compliance with CalOptima's Compliance Program.

The Code of Conduct and Policies and Procedures pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their Employees, agents, and/or Downstream Entities. CalOptima may also develop compliance training and education presentations and/or roundtables for specified FDRs.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to Policies and Procedures, contact information for the Compliance Officer, relevant federal and state Fraud alerts and policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and Members, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the CalOptima Board, FDRs, Employees, and individual CalOptima departments, and Members.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to Board Members, Employees, and FDRs, which contains CalOptima's updated Policies and Procedures.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to Board Members, Employees, FDRs, and Members.
- Electronic Mail – The CEO, Compliance Officer, or their respective Designee, periodically sends out email communications and/or alerts to Board Members, Employees, and FDRs, and/or Members, as applicable.
- CalOptima's Intranet Website – CalOptima maintains an intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to Employees.
- CalOptima's Compliance Intranet Webpage – The Office of Compliance maintains an internal department webpage accessible to CalOptima Employees for communication of different Compliance initiatives, notices, key documents and forms, updates to the Compliance Program, Code of Conduct, and/or Policies and Procedures.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and FWA throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima Employees.
- Written Reports – The Compliance Officer, in coordination with the CEO and Compliance Committee, prepares written reports, no less than quarterly, concerning the status of the Compliance Program to be presented to the CalOptima Board.
- Direct Contact with the Compliance Officer - Board Members, Employees, and FDRs can obtain additional compliance information directly from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

b. Reporting Mechanisms

CalOptima Board Members, Employees, and FDRs have an affirmative duty and are directed in CalOptima's Code of Conduct and Policies and Procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by Board Members, Employees, and/or FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an FDR contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or FWA incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and FWA issues are also provided to Board Members, Employees, FDRs, and Members in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Upon receipt of a report through one (1) of the listed mechanisms, the Compliance Officer, or his/her Designee, shall follow appropriate Policies and Procedures to promptly review, investigate, and resolve such matters. The Compliance Officer, or his/her Designee, shall Monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to Management or Executive Staff*

CalOptima Employees are encouraged to contact their immediate Management or Executive Staff when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. Executive Staff or Management will promptly escalate the report to the Compliance Officer for further investigation and reporting to the CalOptima Compliance Committee. If an Employee is concerned that his/her Management or Executive Staff did not adequately address his/her report or complaint, the Employee may go directly to the Compliance Officer, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with multilingual support, in which CalOptima may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or FWA issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all Board Members, Employees, FDRs, and Members. Members also have access to the Compliance Officer through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline (1-800-447-8477) directly.

3. *Report Directly to the Compliance Officer*

The Compliance Officer is available to receive reports of suspected or actual compliance violations, or FWA issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and Members. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected Fraud and Abuse to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and Members. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic Member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other Corrective Action Plans for violations, as appropriate, with the approval of the Compliance Committee.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, Employees, and FDRs are provided copies of CalOptima's Code of Conduct and the Compliance Plan and have access on CalOptima's internal and external website to applicable Policies and Procedures, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing Corrective Action Plans and Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. Board Members, Employees, and FDRs may be disciplined or Sanctioned, as applicable, for failing to adhere to CalOptima's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts; or
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima's HIPAA privacy and security policies, including actions that harm the privacy of Members, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions.
Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, Sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, Employees are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted.

Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative Sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Employees shall be evaluated annually based on their compliance with CalOptima's Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with Monitoring and Auditing are identified through a combination of activities performed by the Audit & Oversight Department in conjunction with CalOptima contract owners, and functional business owners responsible for on-going monitoring that is performed, risk assessments, Audit & Oversight Committee and Compliance Committee discussions and decisions, and internal and external reporting. Through Monitoring, Auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The Compliance Officer, or his/her Designee, will collaborate with the Compliance Committee to identify areas of focus for Monitoring and Auditing potential non-compliant activity and FWA issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of FDRs. Operations and processes will be evaluated based on: (1) deficiencies found by Regulatory Agencies; (2) deficiencies found by internal and external Audit and Monitoring reports; (3) the institution of new or updated Policies and Procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by CMS and the OIG Work Plan shall be used as resources to evaluate operational risks.

The Compliance Officer, or his/her Designee, will work with the Chief Operating Officer, or his/her Designee, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring Monitoring and Auditing. Those operational areas determined to be high risk may be subject to more frequent Monitoring and Auditing, as well as additional reporting requirements. The risk assessment process will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC, and subsequently to the Compliance Committee, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused Audits may be scheduled based on the results of the ongoing Monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine Auditing and Monitoring Activities to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Policies and Procedures to protect against non-compliance and potential FWA in CalOptima Programs. CalOptima and FDRs shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. Monitoring Activities are regular reviews performed as part of normal operations to

confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An Audit is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a set of standards (e.g., Policies and Procedures, laws, and regulations) used as base measures. As part of the Monitoring process, CalOptima has created a dashboard, which is a Monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with Monitoring operations and outcomes and to identify areas in need of targeted Auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop Monitoring and Auditing work plans. Monitoring and Auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The Monitoring and Auditing work plans are subject to daily updates and additions, and are therefore, working documents. The Compliance Officer, or his/her Designee, in collaboration with the AOC and Compliance Committee, develops the Monitoring and Auditing work plans to address the risks associated with each of CalOptima's Programs.

The Compliance Officer, or his/her Designee, will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate Auditing and Monitoring Activities. Audits for each operational area will be conducted throughout the year consistent with the Monitoring and Auditing work plans. The Compliance Officer, or his/her Designee, will coordinate the Audits with internal audit staff, and, in some cases, with the assistance from an outside vendor. Audit methodologies shall be consistent with regulatory and NCQA requirements and standards. All Audits will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the Audit review is completed, the Audit & Oversight teams will communicate the results to the Compliance Officer and propose follow up corrective action(s), if necessary. The Compliance Officer, or his/her Designee, will provide reports to the CEO and the Compliance Committee concerning the results of the Audits. The AOC reports to the Compliance Officer and the Compliance Committee on Audits that involve FDRs as discussed below. If FWA issues are identified during an Audit, the matter will be further investigated and resolved in a timely manner. In addition, an Audit of the Compliance Program and its effectiveness should occur at least annually, and the results shall be reported to the CalOptima Board.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight Monitoring and Auditing process of FDRs who perform delegated activities. The processes that CalOptima implements to oversee, Monitor, and Audit FDRs are incorporated into CalOptima's written Policies and Procedures, including processes involving Readiness Assessments and Audits of First Tier Entities. CalOptima may implement Corrective Action Plans, Sanctions, and/or revoke its Delegation of duties (in a manner permitted under the contract) if CalOptima

determines that an FDR is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The Compliance Officer, or his/her Designee, determines the process for Monitoring delegated FDRs and develops the annual Monitoring and Audit calendar in order to validate compliance with contractual standards and regulatory requirements. The AOC is responsible for overseeing all of the delegated activities and will review the Readiness Assessment, ensure the annual review of FDRs for delegated functions are completed, conduct formal on-going evaluation of FDR performance and compliance, ensure Downstream and Related Entities are Monitored, and impose Corrective Action Plans and/or Sanctions if the FDR's performance fails to meet statutory and contractual standards and requirements. The AOC may recommend termination of Delegation to the Compliance Committee for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or Delegation agreement with a potential FDR, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's Policies and Procedures, is completed to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, CMS, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not Precluded on the Preclusion List, excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the Medi-Cal Suspended & Ineligible (S&I) Provider List from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the AOC and subsequently the Compliance Committee for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the Delegation agreement specifies the activities CalOptima delegates to the FDRs, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and Audits, and remedies, including disciplinary actions, available to CalOptima. Prior to any Sub-delegation to any Downstream or Related Entity, a First Tier Entity must obtain approval from CalOptima. CalOptima determines who will directly Monitor the Downstream or Related Entity's compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements

intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the FDR and their contractually delegated area(s). Furthermore, FDRs will be required to complete, sign, and return attestation forms confirming the FDR's compliance with new hire and annual training and education requirements, which includes courses on general compliance and FWA as well as Exclusion and Preclusion screening and FWA reporting obligations.

3. *Annual Risk Assessment*

The Compliance Officer, or his/her Designee, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk, or vulnerable, is presented to the AOC for suggested follow-up Audit. FDRs determined to be high risk may be subjected to a more frequent Monitoring and Auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC and subsequently to the Compliance Committee for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the FDR's ability to provide delegated services in accordance with contractual standards and applicable state, CMS, and accreditation requirements, as further detailed in CalOptima's Policies and Procedures. CalOptima may conduct Audits of FDRs at any time. Such Audits may include an evaluation of the FDR's training and education program and materials covering general compliance and FWA, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk FDRs, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual Audit calendar; however, CalOptima does not limit its Auditing schedule to only high-risk FDRs.

If CalOptima has reason to believe the FDR's ability to perform a delegated function is compromised, an additional focused Audit may be performed. The Compliance Officer, or his/her Designee, may also recommend focused Audits upon evaluation of non-compliant trends or reported incidents. The results of these Audits will be reported to the AOC and then to the Compliance Committee.

A focused Audit may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- ► Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- ► Failure to comply with a Corrective Action Plan;
- ► Reported or alleged Fraud, Waste, and/or Abuse;
- ► Significant policy variations that deviate from the CalOptima or state, CMS, or accreditation requirements;
- ► Bankruptcy, or impending bankruptcy, which may impact services to Members (either suspected or reported);
- ► Sale, merger, or acquisition involving the FDR;
- ► Significant changes in the management of the FDR; and/or
- ► Changes in resources which impact CalOptima's and/or the FDR's operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The Compliance Officer, or his/her Designee, shall submit regular reports of all Monitoring, Audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a Corrective Action Plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or his/her Designee. Every Corrective Action Plan is presented to the AOC, in aggregate, with no less than quarterly updates, and recommendations for escalation, as applicable. Supplemental and focused Audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement Sanctions or require remediation by an FDR for failure to fulfill contractual obligations including development and implementation of a Corrective Action Plan. Failure to cooperate with CalOptima in any manner may result in termination of the Delegation agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's Auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the Auditing processes, including Policies and Procedures, Audit tools, and Audit findings, to ensure all regulatory requirements are being Audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- ► The central database of all pending, active, and terminated FDRs to Monitor and track functions, performance, and Audit schedules;
- ► Implementation of an escalation process for compliance/performance issues;
- ► Implementation of a process for validation of Audit tools;

- ► Implementation of a process for noticing FDRs and functional areas of Corrective Action Plans;
- ► Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- ► Implementation of an annual training program for internal staff regarding Delegation standards, Auditing, and Monitoring FDR performance; and/or
- ► Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- ► Evaluations of FDR performance and reporting of delegated functions in accordance with the terms of the agreement;
- ► Number of annual oversight Audits completed within twelve (12) months; and
- ► Corrective Action Plans (CAPs) completed within the established time frame.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's Policies and Procedures, CalOptima performs Participation Status Reviews by searching the OIG –LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, Employees, and/or FDRs are not excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, Employees, and FDRs are required to disclose their Participation Status as part of their initial appointment, employment, commencement of the contract and registration/application processes and when Board Members, Employees, and FDRs receive notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

The Compliance Officer, or his/her Designee, will review reports from Employees responsible for conducting the Participation Status Reviews to ensure Employees record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the Compliance Officer, or his/her Designee, of affirmative findings of a person, or entity's, failure to meet the Participation Status Review requirements. If CalOptima learns that any prospective, or current, Board Member, Employee, or FDR has been proposed for Exclusion, Excluded or Precluded, CalOptima will promptly remove him/her/the FDR from CalOptima's Programs consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of

their suspension, Exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the CMS Preclusion List, consistent with regulatory guidance, applicable policies, and/or contract terms. The Compliance Officer, or his/her Designee, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII. RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's Compliance Program and/or FWA issues, the Compliance Officer, or his/her Designee, shall, upon promptly verifying the facts related to the violation or likely violation, notify the Compliance Committee, as appropriate. The Compliance Committee (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, Sanctions, termination of any agreement and/or any other corrective action consistent with applicable Policies and Procedures, subject to consultation with legal counsel and/or notifying the Governing Body, as appropriate;
- Implementing education and training programs for Board Members, Employees, and/or FDRs, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's Compliance Plan, Code of Conduct, and/or relevant Policies and Procedures to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the Compliance Officer and the Compliance Committee to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable Policies and Procedures after considering such recommendations. The Compliance Officer, or his/her Designee, may Monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning Fraud schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

activity indicates that Fraud may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a Fraud alert is received, CalOptima shall review its Delegation agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the Delegation agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a Fraud alert. With the issuance of a Fraud alert, CMS places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party need to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged Fraud scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes Member complaints, DHCS Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal and/or State Health Care Programs requirements. CalOptima shall also maintain files that contain documented warnings (e.g., Fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, DHCS, CMS, and CMS' Designee, regarding Monitoring of FDRs within CalOptima's network that DHCS, or CMS, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent FWA within a CalOptima Program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of FWA activity. CalOptima shall assess all FDRs for potential Overpayments when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return Overpayments consistent with applicable laws and regulatory guidance.

As required, CalOptima and/or the FDR shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of Overpayment determinations to Regulatory Agencies, as required by law.

When applicable, CalOptima shall return Overpayments made to CalOptima, consistent with applicable state and federal laws and regulatory guidance.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima's Compliance Program. FWA activities are implemented and overseen by CalOptima's Compliance Officer, or his/her Designee, in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for FWA investigations. The Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Compliance Committee, CEO, the CalOptima Board, and Regulatory Agencies.

CalOptima utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Programs is appropriately delivered to Members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

I.FWA TRAINING

As detailed above, FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. FDRs are also required to complete FWA training, as described above. CalOptima's FWA training provides guidance to Board Members, Employees, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Examples of the most common types of Member FWA (see Appendix B, attached hereto and incorporated herein) and FDR FWA (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Programs (e.g., suspicious activities suggesting CalOptima Members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the CalOptima Programs, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average Member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for FDRs, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima's requirement to train Employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima shall provide Board Members, Employees, FDRs, and Members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with CalOptima internal departments, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of FWA. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. Members, FDRs, Employees, law enforcement and Regulatory Agencies, and others may contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect FWA include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record Audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and Monitoring Activities;
- Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and Audits.

b. Data Analytics

CalOptima uses technology and data analysis to reduce FWA externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect FDRs based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, OneCare Connect, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review

of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or Audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by Members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected FWA. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/ or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will

be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a Member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a Member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the Member/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Compliance Officer, Compliance Committee, and CEO.

III.FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU, or a Designee, interviews the individual who reported the FWA, affected Members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of Member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Compliance Officer and Compliance Committee. If a CalOptima internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused Audits, additional investigation, continued Monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential

FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Policies and Procedures, CalOptima shall take appropriate disciplinary, or corrective, action against Board Members, Employees, and/or FDRs related to validated instances of FWA. CalOptima will also assess FDRs for potential Overpayments when reviewing and undertaking corrective actions. Corrective actions will be Monitored by the Compliance Committee, and progressive discipline will be Monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial Sanctions, regulatory reporting, Corrective Action Plans, or termination of the Delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) working days to DHCS after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare, OneCare Connect, or PACE programs.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Members; and/or
- Schemes with large financial risk to CalOptima, or its Members.

IV.ANNUAL FWA EVALUATION

CalOptima's Compliance Committee shall periodically review and evaluate the FWA activities and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Compliance Plan, and other input from applicable sources.

a. Retention of Records

CalOptima shall maintain reports and summaries of FWA activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of Member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of FWA investigations in a secure and confidential manner, regardless of the outcome of an investigation.

b. Confidentiality

CalOptima and its FDRs shall maintain all information associated with suspected, or actual, FWA in confidential files, which may only be released in accordance with applicable laws and CalOptima Policies and Procedures. All participants and attendees of CalOptima's Quality Improvement Committee, Compliance Committee, and respective subcommittees shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the Compliance Program, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the Compliance Program against the elements of an effective Compliance Program as recommended by OIG and required by CMS regulations. The following areas will be reviewed:

- Policies and Procedures;
- Compliance Officer and Compliance Committee;
- Training and education of Board Members, Employees, and FDRs;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal Monitoring and Auditing;
- Delegation oversight;
- Exclusion and Preclusion screening process; and
- Prompt responses to detected offenses.

The Compliance Program will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with Executive Staff and Management, the Compliance Committee, and the CalOptima Board. Updates to the Compliance Program will be based on the results of the evaluation and will be referred to the CalOptima Board for review and approval.

I.PRIVILEGED FILES AND DOCUMENT RETENTION

a. Privileged Files

All privileged files shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the Compliance Officer, CalOptima legal counsel, and the Compliance Committee, where appropriate, shall have access to its contents. All materials in the privileged file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. The privileged file shall contain the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the Compliance Officer;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning FDR delegation agreement interpretations and remedies available to CalOptima.

b. Document Retention

CalOptima shall retain contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.604, 606, 608, and 610, for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract (except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

CalOptima shall maintain the documentation required by HIPAA for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) Policies and Procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by HIPAA; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the Fraud, Waste, and Abuse laws. CalOptima is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from

Principle	Standard
	relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure

Principle	Standard
	effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its Health Networks and third-party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and

Principle	Standard
	other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.
Public Integrity CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.

Principle	Standard
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies,

Principle	Standard
third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or

Principle	Standard
	other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members,	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not

Principle	Standard
providers, and other persons is fundamental to fulfilling its mission and goals.	unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will Monitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their Exclusion or Preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the

Principle	Standard
	delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a Supervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below.

Principle	Standard
	Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by Health Networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight Audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight Audits.

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.
P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight Audit; report by regulatory body; hotline.
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight Audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight Audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit" or "Auditing") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and may require one (1) of several acknowledged certifications..

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima Members" or "Members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered

by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive Staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees, and FDRs comply with applicable law and ethical standards.

Compliance Risk Assessment ("CRA") A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or Monitoring Activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular

functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or **Employees** ("Employee" or "Employees") means any and all employees of CalOptima, including all Executive Staff, Management, officers, managers, Supervisors and other employed personnel, as well as temporary employees and volunteers.

Exclusion ("Exclusion" or "Excluded") means suspension, exclusion, or debarment from participation in federal and/or state health care programs.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

Executive Staff ("Executive Staff") means an employee whose position title is Chief, or Executive Director of one (1) or more departments.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State Health Care Programs") means any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a member under a CalOptima program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

General Services Administration ("GSA**"**) **System for Award Management** ("SAM") is a type of federal government exclusion database and contains the list of Excluded Parties List System (GSA-EPLS). The EPLS consists of federal contractors who have been debarred, Sanctioned, or excluded due to government contract issues or fraud. The database is usually updated on a monthly basis.

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network ("Health Network" or "Health Networks") means the contracted Health Networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Immediate Corrective Action Plan ("ICAP") means the result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Management ("Management") means any employee whose position title is Director, Senior Manager, Manager, or Supervisor of one (1) or more departments.

Medi-Cal Suspended & Ineligible ("S&I") **Provider List** is a list of suspended and ineligible providers that is maintained by DHCS in the Medi-Cal Provider Manual. The list is updated monthly and available online and in print from DHCS.

Medicare Secondary Payer (MSP) Vendor means third-party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare or OneCare Connect for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Multipurpose Senior Services Program ("MSSP") is a program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of Inspector General List of Excluded Individuals and Entities ("OIG LEIE") is an exclusion list and contains individuals and/or entities that have been excluded from participation in federal healthcare programs such as Medicare and Medicaid. This list is usually updated on a monthly basis.

OneCare ("OneCare") is a Medicare Advantage Health Maintenance Organization (HMO) plan offered by CalOptima to provide Medicare covered benefits to Members.

OneCare Connect ("OneCare Connect") is a Medicare-Medicaid health plan offered by CalOptima that contracts with both Medicare and Medi-Cal to provide covered benefits of both programs to Members.

Overpayment ("Overpayment") means a payment disbursed in excess of amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating Providers and Suppliers ("Participating Providers and Suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its Health Networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the Health Networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board Members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Personally Identifiable Information ("PII") means any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmacy Benefit Manager ("PBM") means an entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Program of All-Inclusive Care for the Elderly ("PACE") is a long-term comprehensive health care program that helps older adults to 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.

Preclusion ("Precluded" or "Preclusion List") is a type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Protected Health Information ("PHI") refers to the 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Readiness Assessment ("Readiness Assessment") is an assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CalOptima. The assessment determines the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional area requirements, as determined by CalOptima.

Regulatory Agencies ("Regulatory Agencies") include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

Seniors and Persons with Disabilities ("SPD") means Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third-Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Attachment 3: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

Department	Policy	Policy Title	Revision(s)	Reason for Revision(s)
Audit & Oversight - External	**HH.2027**Δ	Annual Risk Assessment (FDR)	• Clarified the assessment process applies to FDRs as well as FTEs. • Revised language to permit for variation in frequency of monitoring and auditing based on risk level.	Annual review to incorporate revisions to align with the 2021 Compliance Plan and current operations
Regulatory Affairs & Compliance	**HH.2014**Δ	Compliance Program	• Attachment A: FDR Compliance Attestation was revised to align with the Industry Collaboration Effort (ICE) FDR Attestation.	Annual review to incorporate revisions to align with the 2021 Compliance Plan and current operations
Regulatory Affairs & Compliance	**HH.2021**Δ	Exclusion and Preclusion Monitoring	• Included medical group practices, physician medical groups and providers with letters of agreement as entities and individuals subject to monthly exclusion and preclusion monitoring. • Clarified operational departments responsible for monitoring.	Annual review to incorporate revisions to align with the 2021 Compliance Plan and current operations
Regulatory Affairs & Compliance	**HH.2023**Δ	Compliance Training	• Attachment A: FDR Compliance Attestation was revised to align with the Industry Collaboration Effort (ICE) FDR Attestation.	Annual review to incorporate revisions to align with the 2021 Compliance Plan and current operations
Regulatory Affairs & Compliance	**HH.2028**Δ	Code of Conduct	• Attachment A: FDR Compliance Attestation was revised to align with the Industry Collaboration Effort (ICE) FDR Attestation.	Annual review to incorporate revisions to align with the 2021 Compliance Plan and current operations

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the proposed list of policies without substantive revisions for the CalOptima Office of Compliance, by department.

Department	Policy	Policy Title	Summary of Revision(s)	Reason for Revision(s)
Audit & Oversight – External	**GG.1605**	Delegation and Oversight of Credentialing and Recredentialing Activities	• No substantive revisions made since the 2019 annual review.	N/A
Audit & Oversight – External	**GG.1619**	Delegation Oversight	• No substantive revisions made since the 2019 annual review.	N/A
Audit & Oversight – External	**HH.2015**	Health Network Claims Processing	• No substantive revisions made since the 2019 annual review.	N/A
Audit & Oversight – External	**HH.2025**	Health Network Subdelegation and Subcontracting	• No substantive revisions made since the 2019 annual review.	N/A
Audit & Oversight – External	**HH.2026**	Claims Delegation and Oversight	• No substantive revisions made since the 2019 annual review.	N/A
Audit & Oversight - External	**HH.4001Δ**	Audit & Oversight Committee	• No substantive revisions made since the 2019 annual review.	N/A
Audit & Oversight - Internal	**HH.4002**	CalOptima Internal Oversight	• No substantive revisions made since the 2019 annual review.	N/A
Audit & Oversight - Internal	**HH.4003**	Annual Risk Assessment	• No substantive revisions made since the 2019 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.1105Δ**	Fraud, Waste, and Abuse Detection	• No substantive revisions made since the 2019 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.1107Δ**	Fraud, Waste, and Abuse Investigation and Reporting	• No substantive revisions made since the 2019 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.5000Δ**	Provider Overpayment Investigation and Determination	• No substantive revisions made since the 2019 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.5004Δ**	False Claims Act Education	• No substantive revisions made since the 2019 annual review.	N/A

Department	Policy	Policy Title	Summary of Revision(s)	Reason for Revision(s)
Privacy	**HH.3000Δ**	Notice of Privacy Practices	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3001Δ**	Member Access to Designated Record Set	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3002Δ**	Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3003Δ**	Verification of Identity for Disclosure of Protected Health Information	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3004Δ**	Member Request to Amend Records	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3005Δ**	Member Request for Accounting of Disclosures	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3006Δ**	Tracking and Reporting Disclosures of Protected Health Information (PHI)	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3007Δ**	Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3008Δ**	Member Right to Request Confidential Communications	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3009Δ**	Access by Member's Authorized Representative	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3010Δ**	Protected Health Information (PHI) Disclosures Required by Law	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3011Δ**	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3014Δ**	Use of Electronic Mail with Protected Health Information (PHI)	• No substantive revisions made since the 2019 annual review.	N/A

Department	Policy	Policy Title	Summary of Revision(s)	Reason for Revision(s)
Privacy	**HH.3015Δ**	Member Authorization for the Use and Disclosure of Protected Health Information (PHI)	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3016Δ**	Guidelines for Handling Protected Health Information (PHI) Offsite	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3019Δ**	De-identification of Protected Health Information (PHI)	• No substantive revisions made since the 2019 annual review.	N/A
Privacy	**HH.3020Δ**	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI, or Other Unauthorized Use or Disclosure of PHI/PI	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2002Δ**	Sanctions	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2005Δ**	Corrective Action Plan	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2007Δ**	Compliance Committee	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2018Δ**	Compliance and Ethics Hotline	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2019Δ**	Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Policies	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2020Δ**	Conducting Compliance Investigations	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2022Δ**	Record Retention and Access	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2029Δ**	Annual Compliance Program Effectiveness Audit	• No substantive revisions made since the 2019 annual review.	N/A

Department	Policy	Policy Title	Summary of Revision(s)	Reason for Revision(s)
Regulatory Affairs & Compliance	**HH.3012Δ**	Non-Retaliation for Reporting Violations	• No substantive revisions made since the 2019 annual review.	N/A
Regulatory Affairs & Compliance	**MA.9124**	CMS Self-Disclosure	• No substantive revisions made since the 2019 annual review.	N/A

Policy:	HH.2014Δ
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	
Effective Date:	08/01/2008
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy establishes a Compliance Program* to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

II. POLICY

A. CalOptima shall establish a written Compliance Program, in accordance with applicable regulatory and contractual requirements.

B. CalOptima's First Tier, Downstream, and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this Policy.

C. CalOptima shall revise and update the Compliance Program, including the Compliance Plan, and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program, and approving the Compliance Plan and Code of Conduct.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

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* Terms in **bold** are included in the Glossary.

III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the Compliance Plan, Code of Conduct, and related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima operations, or as otherwise indicated to meet the needs of Members.

B. The Compliance Officer shall submit recommended revisions to the Compliance Plan and Code of Conduct, to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan and/or Code of Conduct to the Board of Directors for approval and adoption into the Compliance Program. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, to the Compliance Plan may be implemented without the need to obtain Board of Directors approval.

IV. ATTACHMENT(S)

~~A. CalOptima Compliance Plan~~
~~B.~~A. FDR Compliance Attestation
B. CalOptima Compliance Plan

V. REFERENCE(S)

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Office of Inspector General Guidelines for Operating an Effective Compliance Program
J. Title 42, Code of Federal Regulations (CFR.), §§422.503, 423.504
K. Title 42, Code of Federal Regulations (CFR), §438.608(a)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/12/2013	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2005	MA.9101	Compliance Program	OneCare
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014Δ	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	06/01/2013	MA.9101	Compliance Program	OneCare
Revised	06/01/2014	MA.9101	Compliance Program	OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

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Policy:	HH.2014Δ
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	
Effective Date:	08/01/2008
Revised Date:	TBD

Applicable to:
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C. CalOptima shall revise and update the Compliance Program, including the Compliance Plan, and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program, and approving the Compliance Plan and Code of Conduct.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

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III. PROCEDURE

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B. The Compliance Officer shall submit recommended revisions to the Compliance Plan and Code of Conduct, to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan and/or Code of Conduct to the Board of Directors for approval and adoption into the Compliance Program. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, to the Compliance Plan may be implemented without the need to obtain Board of Directors approval.

IV. ATTACHMENT(S)

A. FDR Compliance Attestation
B. CalOptima Compliance Plan

V. REFERENCE(S)

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2005	MA.9101	Compliance Program	OneCare
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014Δ	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	06/01/2013	MA.9101	Compliance Program	OneCare
Revised	06/01/2014	MA.9101	Compliance Program	OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	Any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

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FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director~~Annie Phillips~~, 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for ~~(~~existing FDRs~~)~~, or sixty (60) calendar days for ~~(~~new FDRs~~)~~ of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐PACE ☐Medi-Cal ☐OneCare ~~HMO SNP~~ ☐~~PACE~~

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and Fraud, Waste and Abuse (FWA) Training**. Provide effective ~~Fraud, Waste and Abuse~~FWA training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use:

(Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records ~~per CMS retention requirement~~ as evidence of completed training)

☐ An internal training program that ~~meets~~ utilizes content available in the CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records ~~per CMS retention requirement~~as evidence of completed training)

Note: If selecting an internal training program that ~~meets~~ aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers ~~: (i) based on their job function~~ within the first ninety (90) days of hire and at least annually thereafter as ~~a~~ condition of appointment, employment or contracting. ~~requirements change; (iii) when such persons work in an area previously found to be non-compliant with program requirements or implicated in past misconduct.~~

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III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

(Select which applies to your organization):

☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct (https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks.aspx)

☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the {Medi-Cal Suspended and Ineligible Provider List} (S & I Medi-Cal), {Health and Human Services} (HHS), {Office of Inspector General} (OIG) List of Excluded Individuals & Entities list, {System for Award Management} (SAM)/{General Services Administration} (GSA) Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (hereafter "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII. **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature	Date
Name (Print)	Organization
Email (Print)	

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

~~Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days (existing FDRs) or sixty (60) calendar days (new FDRs) of the notice accompanying this form.~~

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐OneCare Connect ☐PACE ☐OneCare ~~HMO~~ ☐ Medi-Cal
Please check one of the following: ☐ Our Organization does not offshore any protected health information. **Please skip to Part V below.** ☐ Our Organization does offshore protected health information. **Please complete Offshore Subcontractor Attestation (Part I through Part V) below.**	
~~Are any administrative or other functions conducted on behalf of your Organization by entities located offshore? This shall include employees of your firm, subcontractors and any 3rd party subcontractors.~~ ~~If **NO**, please **complete Part I** and **Part VI** of this form:~~ ~~If **YES**, please skip Part I, and **complete Parts II–VI** of this form~~	~~☐Yes ☐No~~

~~**Part I — Our Firm is Not Using Offshore Subcontractors and/or Employees**~~	
~~**Attestation**~~	~~**Response**~~
~~**Offshore subcontractors**: Our Organization does not currently use offshore subcontractors.~~	~~☐Yes ☐No~~
~~**Offshore employees**: Our Organization does not employ workers who are located offshore.~~	~~☐Yes ☐No~~
~~Name of organization:~~	
~~Name of authorized person:~~	
~~Title:~~	
~~Signature:~~	
~~Date:~~	

Part I~~I~~ — Offshore Subcontractor Information	
Attestation	**Response**
~~**Offshore employees:**~~ Our Organization ~~does employ~~uses an offshore subcontractor or offshore staff to perform functions that support our contract with ~~CaOptima~~CalOptima. ~~workers who are located offshore~~	☐Yes ☐No
Offshore Subcontractor name:	
Offshore Subcontractor country:	

Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II~~I~~ — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor~~: and/or employee:~~	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's~~/employee's~~ objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part ~~IV~~ III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that ~~Medi-Cal and~~ Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore ~~subcontractor/employee~~ subcontracting arrangement prohibits ~~subcontractor/employee~~ subcontractor's access to ~~Medi-Cal and~~ Medicare data not associated with CalOptima's contract with the offshore subcontractor~~/employee~~.	☐Yes ☐No*
C. ~~Describe alternatives considered to avoid providing PHI, and why each alternative was rejected.~~ Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore ~~subcontractor/employee~~ subcontracting arrangement includes all required ~~DHCS (Department of Health Care Services) and/or CMS (Centers for Medicare & Medicaid Services)~~ Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)~~as stipulated within your contract with CalOptima~~	☐Yes ☐No*

~~*Explanation required for "no" response to Part IV items A to D above:~~

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. ~~Yo~~Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by ~~y~~our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. ~~Your~~ Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐Yes ☐No*
~~D. Our organization agrees to notify CalOptima at least 60 days in advance of our intent to use new offshore subcontractor(s) or before employing new offshore staff for a function CalOptima has asked us to perform.~~	~~☐Yes ☐No*~~

***~~Please provide explanation~~Explanation required for all "no" responses ~~to~~to Part III ~~if "no" select for Part V items A to D C and~~and Part IV ~~items A to C~~above:**

Part V~~I~~ — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx~~https://www.caloptima.org/en/Vendors/FDRCompllianceInformation.aspx~~

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director, 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for existing FDRs, or sixty (60) calendar days for new FDRs of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐ OneCare Connect ☐ PACE ☐ Medi-Cal ☐ OneCare

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and Fraud, Waste and Abuse (FWA) Training**. Provide effective FWA training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use:

(Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records as evidence of completed training)

☐ An internal training program that utilizes content available in the CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records as evidence of completed training)

Note: If selecting an internal training program that aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting.

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III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

(Select which applies to your organization):

☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct (https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks.aspx)

☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review to ensure they meet CMS's requirements.

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the Medi-Cal Suspended and Ineligible Provider List (S & I Medi-Cal), Health and Human Services (HHS), Office of Inspector General (OIG) List of Excluded Individuals & Entities list, System for Award Management (SAM)/General Services Administration (GSA) Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (hereafter "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII. **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature	Date
Name (Print)	Organization
Email (Print)	

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐OneCare Connect ☐PACE ☐OneCare ☐ Medi-Cal

Please check one of the following:

☐ Our Organization does not offshore any protected health information.
Please skip to Part V below.

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below.

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima.	☐Yes ☐No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor:	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐Yes ☐No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language. (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐Yes ☐No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐Yes ☐No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

Orange County Health Authority
dba CalOptima

20211 Compliance Plan

(Revised December 20201)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and other CalOptima Programs.*

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and Monitoring responsibilities related to CalOptima's First Tier, Downstream, and Related Entities (FDRs), such as Health Networks, physician groups, Participating Providers, and Suppliers, Pharmacy Benefit Manager (PBM), and consultants. The term FDR is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). Such persons/entities, referred to as FDR herein, include those that directly contract with CalOptima and those that are Downstream or Related Entities (i.e., subcontracts) with CalOptima's First Tier Entities.

CalOptima has developed a comprehensive Compliance Program applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The Compliance Program incorporates all elements of an effective Compliance Program as recommended by the Office of the Inspector General (OIG) and required by CMS regulations. The Compliance Program is continually evolving and may be modified and enhanced based on compliance Monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima Board Members, Employees, and FDRs conduct themselves in accordance with the requirements of CalOptima's Compliance Program.

B. THE COMPLIANCE PLAN

This Compliance Plan sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently Monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective Compliance Program and identifies how CalOptima is implementing each of the fundamental elements of an effective Compliance Program in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the Compliance Plan is designed to provide guidance and to ensure that CalOptima's operations and the practices of its Board Members, Employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted by the Governing Body. It was developed and is managed by the Executive Director of Compliance (hereinafter referred to as the "Compliance Officer") with the Compliance Committee. Due to the dynamic nature of the complex laws governing CalOptima and its programs, the Compliance Plan may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, Employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related Policies and Procedures, as may be amended. Furthermore, Board Members, Employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a Board Member, Employee, and/or FDR has/have any questions about the application, or implementation, of this Compliance Plan, or questions related to the Code of Conduct or CalOptima Policies and Procedures, he or she should seek guidance from the Compliance Officer and/or the CalOptima Office of Compliance.

I. WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Board Members, Employees, and FDRs, CalOptima develops, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written Policies and Procedures.

a. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima Board Members, Employees, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima's commitment to preventing Fraud, Waste, & Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Programs. The Compliance Plan is available on CalOptima's external website for Board Members and FDRs, as well as on CalOptima's ~~internal~~ intranet site, referred to as InfoNet, accessible to all Employees.

b. Policies and Procedures

CalOptima also developed written Policies and Procedures to address specific areas of CalOptima's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima can efficiently Monitor adherence to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, Employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, Employees, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer, or his/her Designee, will ensure that Board Members, Employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

The Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's Policies and Procedures are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key Management staff, meets regularly to review and approve proposed changes and additions to CalOptima's Policies and Procedures. Policies and Procedures are available on CalOptima's internal website and Compliance 360 (C360), a separate web portal accessible to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum.

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c. Code of Conduct

Finally, the Code of Conduct is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the Code of Conduct is to articulate compliance expectations and broad principles that guide CalOptima Board Members, Employees, and FDRs in conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is a separate document from the Compliance Plan and can be found in Appendix A. The Code of Conduct is approved by the CalOptima Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by the CalOptima Board, the Compliance Officer, the Compliance Committee, the Audit & Oversight Committee, and Executive Staff.

a. Governing Body

The CalOptima Board of Directors, as the Governing Body, is responsible for approving, implementing, and Monitoring a Compliance Program governing CalOptima's operations. The CalOptima Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an Employee of CalOptima, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CalOptima Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

To ensure the CalOptima Board exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's Compliance Program, the CalOptima Board:

- Understands the content and operation of CalOptima's Compliance Program;
- Approves the Compliance Program, including this Compliance Plan and the Code of Conduct;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the Compliance Program outcomes, including, but not limited to, results of internal and external Audits;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the Compliance Program;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, Corrective Action Plans, Warning Letters, and/or Sanctions;
- Receives regularly scheduled, periodic updates from CalOptima's Compliance Officer and Compliance Committee, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the Compliance Program.

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The CalOptima Board reviews the measurable indicators of an effective Compliance Program and remains appropriately engaged in overseeing its efficient and successful implementation; however, the CalOptima Board delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The Executive Director of Compliance serves as the Compliance Officer who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and Monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the CalOptima Board at any time. Furthermore, the Compliance Officer ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the CalOptima Board, CEO, CalOptima's Executive Staff and departmental Management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, FDR and internal oversight, Policies and Procedures, and training on compliance activities.

The CalOptima Board delegates the following responsibilities to the Compliance Officer, and/or his/her Designee(s):

- Chair the Compliance Committee, which shall meet no less than quarterly and assists the Compliance Officer in fulfilling his/her responsibilities;
- Ensure that the Compliance Program, including this Compliance Plan and Policies and Procedures, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected Board Members, Employees, and FDRs, as appropriate;
- Oversee and Monitor the implementation of the Compliance Program, and provide regular reports no less than quarterly to the CalOptima Board and CEO summarizing all efforts, including, but not limited to, the Compliance Committee's efforts to ensure adherence to the Compliance Program, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and Audit activities;
- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential FWA received from any source through any reporting method;

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- Design, coordinate, and/or conduct regular internal Audits to ensure the Compliance Program is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of Compliance Program activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board committee and/or to the Board of Directors;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or FWA issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and Monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., DHCS and CMS) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the CalOptima Board, Employees, and FDRs are knowledgeable about CalOptima's Compliance Program, including the Code of Conduct, Policies and Procedures, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate Corrective Action Plans, Sanctions, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and FDRs to ensure Exclusion and Preclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), Medi-Cal Suspended & Ineligible (S&I) Provider List, and the CMS Preclusion List) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of CalOptima's Executive Staff ~~and operational staff~~, as designated by the CEO. The members of the Compliance Committee serve at the discretion of the CEO and may be removed, or added, at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The CalOptima Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Board;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges);

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- Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program;
- Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal, and contractual requirements;
- Recommend and Monitor the development of internal systems and controls to implement CalOptima's standards and Policies and Procedures as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of Monitoring and Auditing of areas in which CalOptima is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its FDRs conduct activities and operations in compliance with the applicable laws and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors.

d. Audit & Oversight Committee (AOC)

The Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is co-led by the Director(s) of Audit & Oversight. The AOC is responsible for overseeing the delegated and internal activities of CalOptima. The Compliance Committee has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the AOC may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the AOC are approved by the majority of a quorum of the AOC. A quorum is defined as one (1) over fifty percent (50%). AOC may approve and/or implement Corrective Action Plans (CAPs); however, recommendations for FDR Sanctions and/or de-Delegation are submitted to the Compliance Committee for final approval. The AOC also contributes to external reviews and accreditation Audits, such as the National Committee for Quality Assurance (NCQA).

Responsibilities of the Audit & Oversight Committee with regard to FDRs include:

- Annual review, revision, and approval of the Audit tools;
- Review findings of the Readiness Assessment to evaluate a potential FDR's ability to perform the delegated function(s);
- Review and approve potential FDR entities for Delegation of functions;
- Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and Monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite Audit;
- Ensure all Downstream and Related Entities are Monitored in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues;
- Propose Sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of Delegation, to the Compliance Committee for unresolved issues of compliance.

Responsibilities of the Audit & Oversight Committee regarding internal business functions include:

- Annual review, revision, and approval of the Audit work plan and Audit tools;
- Conduct formal, ongoing evaluation and Monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing Monitoring, and findings of the annual Audit;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues.
- Initiate and manage other disciplinary actions (e.g., Sanctions, de-delegation) for compliance issues.

e. Executive Staff

The CEO and Executive Staff of CalOptima shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective Compliance Program;
- Receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including

Audit findings, Notices of Non-Compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III.TRAINING

Education and training are critical elements of the Compliance Program. CalOptima requires that all Board Members, Employees, and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's Code of Conduct, compliance obligations, relevant laws, and FWA, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the Compliance Program, and which courses are updated regularly to ensure that Employees are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The Compliance Officer, or his/her Designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the CalOptima Executive Staff and Management are responsible for ensuring that Board Members, Employees, and FDRs complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires Board Members, Employees, and FDRs, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the

Compliance Program are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or FWA issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's HIPAA privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure Members' Protected Health Information (PHI) and Personally Identifiable Information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some FDRs may be exempt or deemed to have met the FWA training and education requirement if the FDR has met the CMS requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program. These training opportunities are available to Managers and Employees depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing Managers the tools and resources to train and share the information with Employees in their respective departments. If additional training related to FWA is required, the Compliance Officer, or his/her Designee, will develop relevant materials.

Employees have access through CalOptima's ~~internal~~ intranet website (referred to as the "InfoNet") to CalOptima's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board Members receive a copy of the Compliance Plan, Code of Conduct, and Policies and Procedures pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the CalOptima Board. Board Members may receive additional compliance training related to the CalOptima Board's role in overseeing and ensuring organizational compliance with CalOptima's Compliance Program.

The Code of Conduct and Policies and Procedures pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their Employees, agents, and/or Downstream Entities. CalOptima may also develop compliance training and education presentations and/or roundtables for specified FDRs.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to Policies and Procedures, contact information for the Compliance Officer, relevant federal and state Fraud alerts and policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and Members, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the CalOptima Board, FDRs, Employees, and individual CalOptima departments, and Members.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to Board Members, Employees, and FDRs, which contains CalOptima's updated Policies and Procedures.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to Board Members, Employees, FDRs, and Members.
- Electronic Mail – The CEO, Compliance Officer, or their respective Designee, periodically sends out email communications and/or alerts to Board Members, Employees, and FDRs, and/or Members, as applicable.
- CalOptima's ~~Internal~~ Intranet Website – CalOptima maintains an ~~internal~~ intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to Employees.
- CalOptima's Compliance ~~Internal Website~~Intranet Webpage – The Office of Compliance maintains an internal department ~~website~~ webpage accessible to CalOptima Employees ~~to~~ for ~~communicate~~ communication of different Compliance initiatives, notices, key documents and forms, ~~and~~ updates to the Compliance Program, Code of Conduct, and/or Policies and Procedures.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and FWA throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima Employees.
- Written Reports – The Compliance Officer, in coordination with the CEO and Compliance Committee, prepares written reports, no less than quarterly, concerning the status of the Compliance Program to be presented to the CalOptima Board.
- Direct Contact with the Compliance Officer - Board Members, Employees, and FDRs can obtain additional compliance information directly from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

b. Reporting Mechanisms

CalOptima Board Members, Employees, and FDRs have an affirmative duty and are directed in CalOptima's Code of Conduct and Policies and Procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by Board Members, Employees, and/or FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an FDR contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or FWA incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and FWA issues are also provided to Board Members, Employees, FDRs, and Members in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Upon receipt of a report through one (1) of the listed mechanisms, the Compliance Officer, or his/her Designee, shall follow appropriate Policies and Procedures to promptly review, investigate, and resolve such matters. The Compliance Officer, or his/her Designee, shall Monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to Management or Executive Staff*

CalOptima Employees are encouraged to contact their immediate Management or Executive Staff when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. Executive Staff or Management will promptly escalate the report to the Compliance Officer for further investigation and reporting to the CalOptima Compliance Committee. If an Employee is concerned that his/her Management or Executive Staff did not adequately address his/her report or complaint, the Employee may go directly to the Compliance Officer, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with multilingual support, in which CalOptima may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or FWA issues. The

Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all Board Members, Employees, FDRs, and Members. Members also have access to the Compliance Officer through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline (1-800-447-8477) directly.

3. *Report Directly to the Compliance Officer*

The Compliance Officer is available to receive reports of suspected or actual compliance violations, or FWA issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and Members. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected Fraud and Abuse to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and Members. CalOptima's non-retaliation policy is communicated along with reporting instructions by

posting information on the CalOptima InfoNet and website, as well as sending periodic Member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other Corrective Action Plans for violations, as appropriate, with the approval of the Compliance Committee.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, Employees, and FDRs are provided copies of CalOptima's Code of Conduct and the Compliance Plan and have access on CalOptima's internal and external website to applicable Policies and Procedures, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing Corrective Action Plans and Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. Board Members, Employees, and FDRs may be disciplined or Ssanctioned, as applicable, for failing to adhere to CalOptima's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts; or
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima's HIPAA privacy and security policies, including actions that harm the privacy of Members, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions.
Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, Sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, Employees are subject to discipline, up to and including termination, and FDRs may be Ssanctioned, or contracts may be terminated, where permitted.

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Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative Sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Employees shall be evaluated annually based on their compliance with CalOptima's Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with Monitoring and Auditing are identified through a combination of activities performed by the Audit & Oversight Department in conjunction with CalOptima contract owners, and functional business owners responsible for on-going monitoring that is performed, risk assessments, Audit & Oversight Committee and Compliance Committee discussions and decisions, and internal and external reporting. Through Monitoring, Auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The Compliance Officer, or his/her Designee, will collaborate with the Compliance Committee to identify areas of focus for Monitoring and Auditing potential non-compliant activity and FWA issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of FDRs. Operations and processes will be evaluated based on: (1) deficiencies found by Regulatory Agencies; (2) deficiencies found by internal and external Audit and Monitoring reports; (3) the institution of new or updated Policies and Procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by CMS and the OIG Work Plan shall be used as resources to evaluate operational risks.

The Compliance Officer, or his/her Designee, will work with the Chief Operating Officer, or his/her Designee, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring M~~m~~onitoring and Auditing. Those operational areas determined to be high risk may be subject to more frequent Monitoring and Auditing, as well as additional reporting requirements. The risk assessment process will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC, and subsequently to the Compliance Committee, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused Audits may be scheduled based on the results of the ongoing M~~m~~onitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine Auditing and Monitoring Activities to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Policies and Procedures to protect against non-compliance and potential FWA in CalOptima Programs. CalOptima and FDRs shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. Monitoring Activities are regular reviews performed as part of normal operations to

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confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An Audit is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a set of standards (e.g., Policies and Procedures, laws, and regulations) used as base measures. As part of the Monitoring process, CalOptima has created a dashboard, which is a Monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with Monitoring operations and outcomes and to identify areas in need of targeted Auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop Monitoring and Auditing work plans. Monitoring and Auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The Monitoring and Auditing work plans are subject to daily updates and additions, and are therefore, working documents. The Compliance Officer, or his/her Designee, in collaboration with the AOC and Compliance Committee, develops the Monitoring and Auditing work plans to address the risks associated with each of CalOptima's Programs.

The Compliance Officer, or his/her Designee, will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate Auditing and Monitoring Activities. Audits for each operational area will be conducted throughout the year consistent with the Monitoring and Auditing work plans. The Compliance Officer, or his/her Designee, will coordinate the Audits with internal audit staff, and, in some cases, with the assistance from an outside vendor. Audit methodologies shall be consistent with regulatory and NCQA requirements and standards. All Audits will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the Audit review is completed, the Audit & Oversight teams will communicate the results to the Compliance Officer and propose follow up corrective action(s), if necessary. The Compliance Officer, or his/her Designee, will provide reports to the CEO and the Compliance Committee concerning the results of the Audits. The AOC reports to the Compliance Officer and the Compliance Committee on Audits that involve FDRs as discussed below. If FWA issues are identified during an Audit, the matter will be further investigated and resolved in a timely manner. In addition, an Audit of the Compliance Program and its effectiveness should occur at least annually, and the results shall be reported to the CalOptima Board.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight Monitoring and Auditing process of FDRs who perform delegated activities. The processes that CalOptima implements to oversee, Monitor, and Audit FDRs are incorporated into CalOptima's written Policies and Procedures, including processes involving Rreadiness Aassessments ~~pre-contractual evaluations~~ and Audits of First Tier Entities. CalOptima may implement Corrective Action Plans, Sanctions, and/or revoke its Delegation of duties (in a manner

permitted under the contract) if CalOptima determines that an FDR is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The Compliance Officer, or his/her Designee, determines the process for Monitoring delegated FDRs and develops the annual Monitoring and Audit calendar in order to validate compliance with contractual standards and regulatory requirements. The AOC is responsible for overseeing all of the delegated activities and will review the Readiness Assessment, ensure the annual review of FDRs for delegated functions are completed, conduct formal on-going evaluation of FDR performance and compliance, ensure Downstream and Related Entities are M~~m~~onitored, and impose Corrective Action Plans and/or Sanctions if the FDR's performance fails to meet statutory and contractual standards and requirements. The AOC may recommend termination of Delegation to the Compliance Committee for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or Delegation agreement with a potential FDR, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's Policies and Procedures, is completed to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, CMS, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not Precluded on the Preclusion List, excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the Medi-Cal Suspended & Ineligible (S&I) Provider List from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the AOC and subsequently the Compliance Committee for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the Delegation agreement specifies the activities CalOptima delegates to the FDRs, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and Audits, and remedies, including disciplinary actions, available to CalOptima. Prior to any Sub-delegation to any Downstream or Related Entity, a First Tier Entity must obtain approval from CalOptima. CalOptima determines who will directly M~~m~~onitor the Downstream or Related Entity's compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements

intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the FDR and their contractually delegated area(s). Furthermore, FDRs will be required to complete, sign, and return attestation forms confirming the FDR's compliance with new hire and annual training and education requirements, which includes courses on general compliance and FWA as well as Exclusion and Preclusion screening and FWA reporting obligations.

3. *Annual Risk Assessment*

The Compliance Officer, or his/her Designee, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (FDR) to determine the FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk, or vulnerable, is presented to the AOC for suggested follow-up Audit. FDRs determined to be high risk may be subjected to a more frequent Monitoring and Auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC and subsequently to the Compliance Committee for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the FDR's ability to provide delegated services in accordance with contractual standards and applicable state, CMS, and accreditation requirements, as further detailed in CalOptima's Policies and Procedures. CalOptima may conduct Audits of FDRs at any time. Such Audits may include an evaluation of the FDR's training and education program and materials covering general compliance and FWA, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk FDRs, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual Audit calendar; however, CalOptima does not limit its Auditing schedule to only high-risk FDRs.

If CalOptima has reason to believe the FDR's ability to perform a delegated function is compromised, an additional focused Audit may be performed. The Compliance Officer, or his/her Designee, may also recommend focused Audits upon evaluation of non-compliant trends or reported incidents. The results of these Audits will be reported to the AOC and then to the Compliance Committee.

A focused Audit may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- ► Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- ► Failure to comply with a Corrective Action Plan;
- ► Reported or alleged Fraud, Waste, and/or Abuse;
- ► Significant policy variations that deviate from the CalOptima or state, CMS, or accreditation requirements;
- ► Bankruptcy, or impending bankruptcy, which may impact services to Members (either suspected or reported);
- ► Sale, merger, or acquisition involving the FDR;
- ► Significant changes in the management of the FDR; and/or
- ► Changes in resources which impact CalOptima's and/or the FDR's operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The Compliance Officer, or his/her Designee, shall submit regular reports of all Mmonitoring, Audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a Corrective Action Plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or his/her Designee. Every Corrective Action Plan is presented to the AOC, in aggregate, with no less than quarterly updates, and recommendations for escalation, as applicable. Supplemental and focused Audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement Sanctions or require remediation by an FDR for failure to fulfill contractual obligations including development and implementation of a Corrective Action Plan. Failure to cooperate with CalOptima in any manner may result in termination of the Delegation agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's Auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the Auditing processes, including Policies and Procedures, Audit tools, and Audit findings, to ensure all regulatory requirements are being Audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- ► The central database of all pending, active, and terminated FDRs to Mmonitor and track functions, performance, and Audit schedules;
- ► Implementation of an escalation process for compliance/performance issues;
- ► Implementation of a process for validation of Audit tools;

- Implementation of a process for noticing FDRs and functional areas of Corrective Action Plans;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding Delegation standards, Auditing, and Monitoring FDR performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of FDR performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight Audits completed within twelve (12) months; and
- Corrective Action Plans (CAPs) completed within the established time frame.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's Policies and Procedures, CalOptima performs Participation Status Reviews by searching the OIG –LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, Employees, and/or FDRs are not excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, Employees, and FDRs are required to disclose their Participation Status as part of their initial appointment, employment, commencement of the contract and registration/application processes and when Board Members, Employees, and FDRs receive notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

The Compliance Officer, or his/her Designee, will review reports from Employees responsible for conducting the Participation Status Reviews to ensure Employees record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the Compliance Officer, or his/her Designee, of affirmative findings of a person, or entity's, failure to meet the Participation Status Review requirements. If CalOptima learns that any prospective, or current, Board Member, Employee, or FDR has been proposed for Exclusion, Excluded or Precluded, CalOptima will promptly remove him/her/the FDR from CalOptima's Programs consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of

their suspension, Exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the CMS Preclusion List, consistent with regulatory guidance, applicable policies, and/or contract terms. The Compliance Officer, or his/her Designee, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII. RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's Compliance Program and/or FWA issues, the Compliance Officer, or his/her Designee, shall, upon promptly verifying the facts related to the violation or likely violation, notify the Compliance Committee, as appropriate. The Compliance Committee (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, Sanctions, termination of any agreement and/or any other corrective action consistent with applicable Policies and Procedures, subject to consultation with legal counsel and/or notifying the Governing Body, as appropriate;
- Implementing education and training programs for Board Members, Employees, and/or FDRs, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's Compliance Plan, Code of Conduct, and/or relevant Policies and Procedures to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the Compliance Officer and the Compliance Committee to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable Policies and Procedures after considering such recommendations. The Compliance Officer, or his/her Designee, may Mmonitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning Fraud schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

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activity indicates that Fraud may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a Fraud alert is received, CalOptima shall review its Delegation agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the Delegation agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a Fraud alert. With the issuance of a Fraud alert, CMS places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party need to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged Fraud scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes Member complaints, DHCS Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal and/or State Health Care Programs requirements. CalOptima shall also maintain files that contain documented warnings (e.g., Fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, DHCS, CMS, and CMS' Designee, regarding Monitoring of FDRs within CalOptima's network that DHCS, or CMS, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent FWA within a CalOptima Program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of FWA activity. CalOptima shall assess all FDRs for potential Overpayments when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return Overpayments consistent with applicable laws and regulatory guidance.

As required, CalOptima and/or the FDR shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of Overpayment determinations to Regulatory Agencies, as required by law.

When applicable, CalOptima shall return Overpayments made to CalOptima, consistent with applicable state and federal laws and regulatory guidance.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima's Compliance Program. FWA activities are implemented and overseen by CalOptima's Compliance Officer, or his/her Designee, in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for FWA investigations. The Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Compliance Committee, CEO, the CalOptima Board, and Regulatory Agencies.

CalOptima utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Programs is appropriately delivered to Members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

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I.FWA TRAINING

As detailed above, FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. FDRs are also required to complete FWA training, as described above. CalOptima's FWA training provides guidance to Board Members, Employees, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Examples of the most common types of Member FWA (see Appendix B, attached hereto and incorporated herein) and FDR FWA (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Programs (e.g., suspicious activities suggesting CalOptima Members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the CalOptima Programs, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average Member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for FDRs, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima's requirement to train Employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima shall provide Board Members, Employees, FDRs, and Members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with CalOptima internal departments, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of FWA. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. Members, FDRs, Employees, law enforcement and Regulatory Agencies, and others may contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect FWA include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record Audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and Monitoring Activities;
- Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and Audits.

b. Data Analytics

CalOptima uses technology and data analysis to reduce FWA externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect FDRs based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, OneCare Connect, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review

of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or Audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by Members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected FWA. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/ or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will

be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a Member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a Member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the Member/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Compliance Officer, Compliance Committee, and CEO.

III.FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU, or a Designee, interviews the individual who reported the FWA, affected Members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of Member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Compliance Officer and Compliance Committee. If a CalOptima internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused Audits, additional investigation, continued Monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential

FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Policies and Procedures, CalOptima shall take appropriate disciplinary, or corrective, action against Board Members, Employees, and/or FDRs related to validated instances of FWA. CalOptima will also assess FDRs for potential Overpayments when reviewing and undertaking corrective actions. Corrective actions will be Mmonitored by the Compliance Committee, and progressive discipline will be Mmonitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial Sanctions, regulatory reporting, Corrective Action Plans, or termination of the Delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) working days to DHCS after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare, OneCare Connect, or PACE programs.~~case is reported to CalOptima's SIU.~~

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Members; and/or
- Schemes with large financial risk to CalOptima, or its Members.

IV. ANNUAL FWA EVALUATION

CalOptima's Compliance Committee shall periodically review and evaluate the FWA activities and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Compliance Plan, and other input from applicable sources.

a. Retention of Records

CalOptima shall maintain reports and summaries of FWA activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of Member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of FWA investigations in a secure and confidential manner, regardless of the outcome of an investigation.

b. Confidentiality

CalOptima and its FDRs shall maintain all information associated with suspected, or actual, FWA in confidential files, which may only be released in accordance with applicable laws and CalOptima Policies and Procedures. All participants and attendees of CalOptima's Quality Improvement Committee, Compliance Committee, and respective subcommittees shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the Compliance Program, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the Compliance Program against the elements of an effective Compliance Program as recommended by OIG and required by CMS regulations. The following areas will be reviewed:

- Policies and Procedures;
- Compliance Officer and Compliance Committee;
- Training and education of Board Members, Employees, and FDRs;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal Monitoring and Auditing;
- Delegation oversight;
- Exclusion and Preclusion screening process; and
- Prompt responses to detected offenses.

The Compliance Program will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with Executive Staff and Management, the Compliance Committee, and the CalOptima Board. Updates to the Compliance Program will be based on the results of the evaluation and will be referred to the CalOptima Board for review and approval.

I.PRIVILEGED FILES AND DOCUMENT RETENTION

a. Privileged Files

All privileged files shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the Compliance Officer, CalOptima legal counsel, and the Compliance Committee, where appropriate, shall have access to its contents. All materials in the privileged file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. The privileged file shall contain the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the Compliance Officer;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning FDR delegation agreement interpretations and remedies available to CalOptima.

b. Document Retention

CalOptima shall retain contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.604, 606, 608, and 610, for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract (except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

CalOptima shall maintain the documentation required by HIPAA for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) Policies and Procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by HIPAA; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the Fraud, Waste, and Abuse laws. CalOptima is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from

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Principle	Standard
	relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure

Principle	Standard
	effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its Health Networks and third-party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and

Principle	Standard
	other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.
Public Integrity CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.

Principle	Standard
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies,

Principle	Standard
third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or

Principle	Standard
	other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members,	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not

Principle	Standard
providers, and other persons is fundamental to fulfilling its mission and goals.	unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will M~~m~~onitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their Exclusion or Preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the

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Principle	Standard
	delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a Ssupervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below.

Principle	Standard
	Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by Health Networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

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Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight Audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight Audits.

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FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.
P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight Audit; report by regulatory body; hotline.
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight Audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight Audits; verification survey.

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Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

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E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit" or "Auditing") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and may require one (1) of several acknowledged certifications. ~~and normally performed by individuals with one (1) of several acknowledged certifications.~~

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima Members" or "Members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima

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under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive Staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees, and FDRs comply with applicable law and ethical standards.

Compliance Risk Assessment ("CRA") A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or Monitoring Activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

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Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or **Employees** ("Employee" or "Employees") means any and all employees of CalOptima, including all Executive Staff, Management, officers, managers, Ssupervisors and other employed personnel, as well as temporary employees and volunteers.

Exclusion ("Exclusion" or "Excluded") means suspension, exclusion, or debarment from participation in federal and/or state health care programs.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

Executive Staff ("Executive Staff") means an employee whose position title is Chief, or Executive Director of one (1) or more departments.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State Health Care Programs") means any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a member under a CalOptima program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

General Services Administration ("GSA**"**) **System for Award Management** ("SAM") is a type of federal government exclusion database and contains the list of Excluded Parties List System (GSA-EPLS). The EPLS consists of federal contractors who have been debarred, Ssanctioned, or excluded due to government contract issues or fraud. The database is usually updated on a monthly basis.

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network ("Health Network" or "Health Networks") means the contracted Health Networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health

information, as amended.

Immediate Corrective Action Plan ("ICAP") means the result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Management ("Management") means any employee whose position title is Director, Senior Manager, Manager, or Supervisor of one (1) or more departments.

Medi-Cal Suspended & Ineligible ("S&I") **Provider List** is a list of suspended and ineligible providers that is maintained by DHCS in the Medi-Cal Provider Manual. The list is updated monthly and available online and in print from DHCS.

Medicare Secondary Payer (MSP) Vendor means third-party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare or OneCare Connect for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Multipurpose Senior Services Program ("MSSP") is a program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of Inspector General List of Excluded Individuals and Entities ("OIG LEIE") is an exclusion list and contains individuals and/or entities that have been excluded from participation in federal healthcare programs such as Medicare and Medicaid. This list is usually updated on a monthly basis.

OneCare ("OneCare") is a Medicare Advantage Health Maintenance Organization (HMO) plan offered by CalOptima to provide Medicare covered benefits to Members.

OneCare Connect ("OneCare Connect") is a Medicare-Medicaid health plan offered by CalOptima that contracts with both Medicare and Medi-Cal to provide covered benefits of both programs to Members.

Overpayment ("Overpayment") means a payment disbursed in excess of amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating Providers and Suppliers ("Participating Providers and Suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its Health Networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the Health Networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board Members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Personally Identifiable Information ("PII") means any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmacy Benefit Manager ("PBM") means an entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Program of All-Inclusive Care for the Elderly ("PACE") is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and

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provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

Preclusion ("Precluded" or "Preclusion List") is a type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Protected Health Information ("PHI") refers to the 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Readiness Assessment ("Readiness Assessment") is an assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CalOptima. The assessment determines the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional area requirements, as determined by CalOptima.

Regulatory Agencies ("Regulatory Agencies") include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

Seniors and Persons with Disabilities ("SPD") means Medi-Cal beneficiaries who fall under specific

Aged and Disabled Aid Codes as defined by the DHCS.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third-Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Orange County Health Authority
dba CalOptima

2021 Compliance Plan

(Revised December 2020)

Document maintained by:
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CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and other CalOptima Programs.

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and Monitoring responsibilities related to CalOptima's First Tier, Downstream, and Related Entities (FDRs), such as Health Networks, physician groups, Participating Providers, and Suppliers, Pharmacy Benefit Manager (PBM), and consultants. The term FDR is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). Such persons/entities, referred to as FDR herein, include those that directly contract with CalOptima and those that are Downstream or Related Entities (i.e., subcontracts) with CalOptima's First Tier Entities.

CalOptima has developed a comprehensive Compliance Program applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The Compliance Program incorporates all elements of an effective Compliance Program as recommended by the Office of the Inspector General (OIG) and required by CMS regulations. The Compliance Program is continually evolving and may be modified and enhanced based on compliance Monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima Board Members, Employees, and FDRs conduct themselves in accordance with the requirements of CalOptima's Compliance Program.

B. THE COMPLIANCE PLAN

This Compliance Plan sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently Monitor adherence to all applicable laws, regulations, and guidelines. The Compliance Plan addresses the fundamental elements of an effective Compliance Program and identifies how CalOptima is implementing each of the fundamental elements of an effective Compliance Program in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the Compliance Plan is designed to provide guidance and to ensure that CalOptima's operations and the practices of its Board Members, Employees, and FDRs comply with contractual requirements, ethical standards, and applicable law.

This Compliance Plan is adopted by the Governing Body. It was developed and is managed by the Executive Director of Compliance (hereinafter referred to as the "Compliance Officer") with the Compliance Committee. Due to the dynamic nature of the complex laws governing CalOptima and its programs, the Compliance Plan may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board Members, Employees, and FDRs are expected to review and adhere to the requirements and standards set forth in the Compliance Plan, the Code of Conduct, and all related Policies and Procedures, as may be amended. Furthermore, Board Members, Employees, and FDRs are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a Board Member, Employee, and/or FDR has/have any questions about the application, or implementation, of this Compliance Plan, or questions related to the Code of Conduct or CalOptima Policies and Procedures, he or she should seek guidance from the Compliance Officer and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of Board Members, Employees, and FDRs, CalOptima develops, maintains, and distributes its written standards in the form of this Compliance Plan, a separate Code of Conduct, and written Policies and Procedures.

a. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima Board Members, Employees, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima's commitment to preventing Fraud, Waste, & Abuse (FWA), and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Programs. The Compliance Plan is available on CalOptima's external website for Board Members and FDRs, as well as on CalOptima's intranet site, referred to as InfoNet, accessible to all Employees.

b. Policies and Procedures

CalOptima also developed written Policies and Procedures to address specific areas of CalOptima's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima can efficiently Monitor adherence to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, Employees, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, Employees, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Compliance Officer, or his/her Designee, will ensure that Board Members, Employees, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

The Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's Policies and Procedures are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key Management staff, meets regularly to review and approve proposed changes and additions to CalOptima's Policies and Procedures. Policies and Procedures are available on CalOptima's internal website and Compliance 360 (C360), a separate web portal accessible to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum.

c. Code of Conduct

Finally, the Code of Conduct is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the Code of Conduct is to articulate compliance expectations and broad principles that guide CalOptima Board Members, Employees, and FDRs in conducting their business activities in a professional, ethical, and lawful manner. The Code of Conduct is a separate document from the Compliance Plan and can be found in Appendix A. The Code of Conduct is approved by the CalOptima Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the Compliance Program requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by the CalOptima Board, the Compliance Officer, the Compliance Committee, the Audit & Oversight Committee, and Executive Staff.

a. Governing Body

The CalOptima Board of Directors, as the Governing Body, is responsible for approving, implementing, and Monitoring a Compliance Program governing CalOptima's operations. The CalOptima Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Compliance Officer. The Compliance Officer is an Employee of CalOptima, who handles compliance oversight and activities full-time. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the CalOptima Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation.

To ensure the CalOptima Board exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's Compliance Program, the CalOptima Board:

- Understands the content and operation of CalOptima's Compliance Program;
- Approves the Compliance Program, including this Compliance Plan and the Code of Conduct;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the Compliance Program outcomes, including, but not limited to, results of internal and external Audits;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the Compliance Program;
- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, Corrective Action Plans, Warning Letters, and/or Sanctions;
- Receives regularly scheduled, periodic updates from CalOptima's Compliance Officer and Compliance Committee, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the Compliance Program.

The CalOptima Board reviews the measurable indicators of an effective Compliance Program and remains appropriately engaged in overseeing its efficient and successful implementation; however, the CalOptima Board delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The Executive Director of Compliance serves as the Compliance Officer who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and Monitors the day-to-day activities of the Compliance Program. The Compliance Officer reports directly to the CEO and the Compliance Committee on the activities and status of the Compliance Program. The Compliance Officer has authority to report matters directly to the CalOptima Board at any time. Furthermore, the Compliance Officer ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The Compliance Officer interacts with the CalOptima Board, CEO, CalOptima's Executive Staff and departmental Management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, FDR and internal oversight, Policies and Procedures, and training on compliance activities.

The CalOptima Board delegates the following responsibilities to the Compliance Officer, and/or his/her Designee(s):

- Chair the Compliance Committee, which shall meet no less than quarterly and assists the Compliance Officer in fulfilling his/her responsibilities;
- Ensure that the Compliance Program, including this Compliance Plan and Policies and Procedures, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected Board Members, Employees, and FDRs, as appropriate;
- Oversee and Monitor the implementation of the Compliance Program, and provide regular reports no less than quarterly to the CalOptima Board and CEO summarizing all efforts, including, but not limited to, the Compliance Committee's efforts to ensure adherence to the Compliance Program, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and Audit activities;
- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential FWA received from any source through any reporting method;

- Design, coordinate, and/or conduct regular internal Audits to ensure the Compliance Program is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of Compliance Program activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board committee and/or to the Board of Directors;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or FWA issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and Monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., DHCS and CMS) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the CalOptima Board, Employees, and FDRs are knowledgeable about CalOptima's Compliance Program, including the Code of Conduct, Policies and Procedures, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate Corrective Action Plans, Sanctions, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and FDRs to ensure Exclusion and Preclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), Medi-Cal Suspended & Ineligible (S&I) Provider List, and the CMS Preclusion List) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The Compliance Committee, chaired by the Compliance Officer, is composed of CalOptima's Executive Staff, as designated by the CEO. The members of the Compliance Committee serve at the discretion of the CEO and may be removed, or added, at any time. The role of the Compliance Committee is to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program.

The CalOptima Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Board;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges);

- Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program;
- Review, approve, and/or update Policies and Procedures to ensure the successful implementation and effectiveness of the Compliance Program consistent with regulatory, legal, and contractual requirements;
- Recommend and Monitor the development of internal systems and controls to implement CalOptima's standards and Policies and Procedures as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Compliance Officer accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of Monitoring and Auditing of areas in which CalOptima is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its FDRs conduct activities and operations in compliance with the applicable laws and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Board of Directors.

d. Audit & Oversight Committee (AOC)

The Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is co-led by the Director(s) of Audit & Oversight. The AOC is responsible for overseeing the delegated and internal activities of CalOptima. The Compliance Committee has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the AOC may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the AOC are approved by the majority of a quorum of the AOC. A quorum is defined as one (1) over fifty percent (50%). AOC may approve and/or implement Corrective Action Plans (CAPs); however, recommendations for FDR Sanctions and/or de-Delegation are submitted to the Compliance Committee for final approval. The AOC also contributes to external reviews and accreditation Audits, such as the National Committee for Quality Assurance (NCQA).

Responsibilities of the Audit & Oversight Committee with regard to FDRs include:

- Annual review, revision, and approval of the Audit tools;
- Review findings of the Readiness Assessment to evaluate a potential FDR's ability to perform the delegated function(s);
- Review and approve potential FDR entities for Delegation of functions;
- Ensure written agreements with each delegated FDR clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and Monitoring of FDR performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite Audit;
- Ensure all Downstream and Related Entities are Monitored in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues;
- Propose Sanctions, subject to the Compliance Committee's approval, if an FDR's performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of Delegation, to the Compliance Committee for unresolved issues of compliance.

Responsibilities of the Audit & Oversight Committee regarding internal business functions include:

- Annual review, revision, and approval of the Audit work plan and Audit tools;
- Conduct formal, ongoing evaluation and Monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing Monitoring, and findings of the annual Audit;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage Corrective Action Plans (CAPs) for compliance issues.
- Initiate and manage other disciplinary actions (e.g., Sanctions, de-delegation) for compliance issues.

e. Executive Staff

The CEO and Executive Staff of CalOptima shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective Compliance Program;
- Receive periodic reports from the Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including

Audit findings, Notices of Non-Compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III.TRAINING

Education and training are critical elements of the Compliance Program. CalOptima requires that all Board Members, Employees, and FDRs complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's Code of Conduct, compliance obligations, relevant laws, and FWA, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the Compliance Program, and which courses are updated regularly to ensure that Employees are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The Compliance Officer, or his/her Designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The Compliance Officer and the CalOptima Executive Staff and Management are responsible for ensuring that Board Members, Employees, and FDRs complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's Code of Conduct to Board Members, Employees, and FDRs. Board Members, Employees, and FDRs are required to sign an attestation acknowledging receipt, review, and understanding of the Code of Conduct within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires Board Members, Employees, and FDRs, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the Compliance Program; FWA training; Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the

Compliance Program are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or FWA issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's HIPAA privacy and security training course covers the administrative, technical, and physical safeguards necessary to secure Members' Protected Health Information (PHI) and Personally Identifiable Information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some FDRs may be exempt or deemed to have met the FWA training and education requirement if the FDR has met the CMS requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the Compliance Program. These training opportunities are available to Managers and Employees depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing Managers the tools and resources to train and share the information with Employees in their respective departments. If additional training related to FWA is required, the Compliance Officer, or his/her Designee, will develop relevant materials.

Employees have access through CalOptima's intranet website (referred to as the "InfoNet") to CalOptima's Policies and Procedures governing the Compliance Program and pertinent to their respective roles and responsibilities. Employees may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board Members receive a copy of the Compliance Plan, Code of Conduct, and Policies and Procedures pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the CalOptima Board. Board Members may receive additional compliance training related to the CalOptima Board's role in overseeing and ensuring organizational compliance with CalOptima's Compliance Program.

The Code of Conduct and Policies and Procedures pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to FDRs upon commencement of the FDR contract. FDRs are required to disseminate copies of the Code of Conduct and Policies and Procedures to their Employees, agents, and/or Downstream Entities. CalOptima may also develop compliance training and education presentations and/or roundtables for specified FDRs.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the Compliance Program and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to Policies and Procedures, contact information for the Compliance Officer, relevant federal and state Fraud alerts and policy letters, pending/new legislation reports, and advisory bulletins from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and Members, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the CalOptima Board, FDRs, Employees, and individual CalOptima departments, and Members.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to Board Members, Employees, and FDRs, which contains CalOptima's updated Policies and Procedures.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to Board Members, Employees, FDRs, and Members.
- Electronic Mail – The CEO, Compliance Officer, or their respective Designee, periodically sends out email communications and/or alerts to Board Members, Employees, and FDRs, and/or Members, as applicable.
- CalOptima's Intranet Website – CalOptima maintains an intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to Employees.
- CalOptima's Compliance Intranet Webpage – The Office of Compliance maintains an internal department webpage accessible to CalOptima Employees for communication of different Compliance initiatives, notices, key documents and forms, updates to the Compliance Program, Code of Conduct, and/or Policies and Procedures.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and FWA throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima Employees.
- Written Reports – The Compliance Officer, in coordination with the CEO and Compliance Committee, prepares written reports, no less than quarterly, concerning the status of the Compliance Program to be presented to the CalOptima Board.
- Direct Contact with the Compliance Officer - Board Members, Employees, and FDRs can obtain additional compliance information directly from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

b. Reporting Mechanisms

CalOptima Board Members, Employees, and FDRs have an affirmative duty and are directed in CalOptima's Code of Conduct and Policies and Procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by Board Members, Employees, and/or FDRs to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an FDR contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or FWA incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and FWA issues are also provided to Board Members, Employees, FDRs, and Members in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Upon receipt of a report through one (1) of the listed mechanisms, the Compliance Officer, or his/her Designee, shall follow appropriate Policies and Procedures to promptly review, investigate, and resolve such matters. The Compliance Officer, or his/her Designee, shall Monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to Management or Executive Staff*

CalOptima Employees are encouraged to contact their immediate Management or Executive Staff when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. Executive Staff or Management will promptly escalate the report to the Compliance Officer for further investigation and reporting to the CalOptima Compliance Committee. If an Employee is concerned that his/her Management or Executive Staff did not adequately address his/her report or complaint, the Employee may go directly to the Compliance Officer, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with multilingual support, in which CalOptima may receive anonymous issues on a confidential basis. Members are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or FWA issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all Board Members, Employees, FDRs, and Members. Members also have access to the Compliance Officer through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline (1-800-447-8477) directly.

3. *Report Directly to the Compliance Officer*

The Compliance Officer is available to receive reports of suspected or actual compliance violations, or FWA issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from Board Members, Employees, FDRs and Members. The Compliance Officer may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. FDRs are generally contractually obligated to report suspected Fraud and Abuse to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and Members. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic Member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the Compliance Officer will review and enforce disciplinary and/or other Corrective Action Plans for violations, as appropriate, with the approval of the Compliance Committee.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board Members, Employees, and FDRs are provided copies of CalOptima's Code of Conduct and the Compliance Plan and have access on CalOptima's internal and external website to applicable Policies and Procedures, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing Corrective Action Plans and Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. Board Members, Employees, and FDRs may be disciplined or Sanctioned, as applicable, for failing to adhere to CalOptima's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts; or
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima's HIPAA privacy and security policies, including actions that harm the privacy of Members, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions.
Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, Sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, Employees are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted.

Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative Sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Employees shall be evaluated annually based on their compliance with CalOptima's Compliance Program. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with Monitoring and Auditing are identified through a combination of activities performed by the Audit & Oversight Department in conjunction with CalOptima contract owners, and functional business owners responsible for on-going monitoring that is performed, risk assessments, Audit & Oversight Committee and Compliance Committee discussions and decisions, and internal and external reporting. Through Monitoring, Auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The Compliance Officer, or his/her Designee, will collaborate with the Compliance Committee to identify areas of focus for Monitoring and Auditing potential non-compliant activity and FWA issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of FDRs. Operations and processes will be evaluated based on: (1) deficiencies found by Regulatory Agencies; (2) deficiencies found by internal and external Audit and Monitoring reports; (3) the institution of new or updated Policies and Procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by CMS and the OIG Work Plan shall be used as resources to evaluate operational risks.

The Compliance Officer, or his/her Designee, will work with the Chief Operating Officer, or his/her Designee, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring Monitoring and Auditing. Those operational areas determined to be high risk may be subject to more frequent Monitoring and Auditing, as well as additional reporting requirements. The risk assessment process will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC, and subsequently to the Compliance Committee, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused Audits may be scheduled based on the results of the ongoing Monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine Auditing and Monitoring Activities to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Policies and Procedures to protect against non-compliance and potential FWA in CalOptima Programs. CalOptima and FDRs shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. Monitoring Activities are regular reviews performed as part of normal operations to

confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An Audit is a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a set of standards (e.g., Policies and Procedures, laws, and regulations) used as base measures. As part of the Monitoring process, CalOptima has created a dashboard, which is a Monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with Monitoring operations and outcomes and to identify areas in need of targeted Auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop Monitoring and Auditing work plans. Monitoring and Auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The Monitoring and Auditing work plans are subject to daily updates and additions, and are therefore, working documents. The Compliance Officer, or his/her Designee, in collaboration with the AOC and Compliance Committee, develops the Monitoring and Auditing work plans to address the risks associated with each of CalOptima's Programs.

The Compliance Officer, or his/her Designee, will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate Auditing and Monitoring Activities. Audits for each operational area will be conducted throughout the year consistent with the Monitoring and Auditing work plans. The Compliance Officer, or his/her Designee, will coordinate the Audits with internal audit staff, and, in some cases, with the assistance from an outside vendor. Audit methodologies shall be consistent with regulatory and NCQA requirements and standards. All Audits will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the Audit review is completed, the Audit & Oversight teams will communicate the results to the Compliance Officer and propose follow up corrective action(s), if necessary. The Compliance Officer, or his/her Designee, will provide reports to the CEO and the Compliance Committee concerning the results of the Audits. The AOC reports to the Compliance Officer and the Compliance Committee on Audits that involve FDRs as discussed below. If FWA issues are identified during an Audit, the matter will be further investigated and resolved in a timely manner. In addition, an Audit of the Compliance Program and its effectiveness should occur at least annually, and the results shall be reported to the CalOptima Board.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to CMS, DHCS, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight Monitoring and Auditing process of FDRs who perform delegated activities. The processes that CalOptima implements to oversee, Monitor, and Audit FDRs are incorporated into CalOptima's written Policies and Procedures, including processes involving Readiness Assessments and Audits of First Tier Entities. CalOptima may implement Corrective Action Plans, Sanctions, and/or revoke its Delegation of duties (in a manner permitted under the contract) if CalOptima

determines that an FDR is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The Compliance Officer, or his/her Designee, determines the process for Monitoring delegated FDRs and develops the annual Monitoring and Audit calendar in order to validate compliance with contractual standards and regulatory requirements. The AOC is responsible for overseeing all of the delegated activities and will review the Readiness Assessment, ensure the annual review of FDRs for delegated functions are completed, conduct formal on-going evaluation of FDR performance and compliance, ensure Downstream and Related Entities are Monitored, and impose Corrective Action Plans and/or Sanctions if the FDR's performance fails to meet statutory and contractual standards and requirements. The AOC may recommend termination of Delegation to the Compliance Committee for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or Delegation agreement with a potential FDR, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's Policies and Procedures, is completed to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, CMS, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not Precluded on the Preclusion List, excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the Medi-Cal Suspended & Ineligible (S&I) Provider List from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the AOC and subsequently the Compliance Committee for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the Delegation agreement specifies the activities CalOptima delegates to the FDRs, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and Audits, and remedies, including disciplinary actions, available to CalOptima. Prior to any Sub-delegation to any Downstream or Related Entity, a First Tier Entity must obtain approval from CalOptima. CalOptima determines who will directly Monitor the Downstream or Related Entity's compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements

intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the FDR and their contractually delegated area(s). Furthermore, FDRs will be required to complete, sign, and return attestation forms confirming the FDR's compliance with new hire and annual training and education requirements, which includes courses on general compliance and FWA as well as Exclusion and Preclusion screening and FWA reporting obligations.

3. *Annual Risk Assessment*

The Compliance Officer, or his/her Designee, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk, or vulnerable, is presented to the AOC for suggested follow-up Audit. FDRs determined to be high risk may be subjected to a more frequent Monitoring and Auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Compliance Officer, or his/her Designee, and presented to the AOC and subsequently to the Compliance Committee for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the FDR's ability to provide delegated services in accordance with contractual standards and applicable state, CMS, and accreditation requirements, as further detailed in CalOptima's Policies and Procedures. CalOptima may conduct Audits of FDRs at any time. Such Audits may include an evaluation of the FDR's training and education program and materials covering general compliance and FWA, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk FDRs, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual Audit calendar; however, CalOptima does not limit its Auditing schedule to only high-risk FDRs.

If CalOptima has reason to believe the FDR's ability to perform a delegated function is compromised, an additional focused Audit may be performed. The Compliance Officer, or his/her Designee, may also recommend focused Audits upon evaluation of non-compliant trends or reported incidents. The results of these Audits will be reported to the AOC and then to the Compliance Committee.

A focused Audit may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- ► Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- ► Failure to comply with a Corrective Action Plan;
- ► Reported or alleged Fraud, Waste, and/or Abuse;
- ► Significant policy variations that deviate from the CalOptima or state, CMS, or accreditation requirements;
- ► Bankruptcy, or impending bankruptcy, which may impact services to Members (either suspected or reported);
- ► Sale, merger, or acquisition involving the FDR;
- ► Significant changes in the management of the FDR; and/or
- ► Changes in resources which impact CalOptima's and/or the FDR's operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The Compliance Officer, or his/her Designee, shall submit regular reports of all Monitoring, Audit, and corrective action activities to the Compliance Committee. In instances where non-compliance is identified, a Corrective Action Plan shall be developed by the FDR and reviewed and approved by the Compliance Officer, or his/her Designee. Every Corrective Action Plan is presented to the AOC, in aggregate, with no less than quarterly updates, and recommendations for escalation, as applicable. Supplemental and focused Audits of FDRs, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement Sanctions or require remediation by an FDR for failure to fulfill contractual obligations including development and implementation of a Corrective Action Plan. Failure to cooperate with CalOptima in any manner may result in termination of the Delegation agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's Auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the Auditing processes, including Policies and Procedures, Audit tools, and Audit findings, to ensure all regulatory requirements are being Audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- ► The central database of all pending, active, and terminated FDRs to Monitor and track functions, performance, and Audit schedules;
- ► Implementation of an escalation process for compliance/performance issues;
- ► Implementation of a process for validation of Audit tools;

- ► Implementation of a process for noticing FDRs and functional areas of Corrective Action Plans;
- ► Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- ► Implementation of an annual training program for internal staff regarding Delegation standards, Auditing, and Monitoring FDR performance; and/or
- ► Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- ► Evaluations of FDR performance and reporting of delegated functions in accordance with the terms of the agreement;
- ► Number of annual oversight Audits completed within twelve (12) months; and
- ► Corrective Action Plans (CAPs) completed within the established time frame.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's Policies and Procedures, CalOptima performs Participation Status Reviews by searching the OIG –LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, Employees, and/or FDRs are not excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, Employees, and FDRs are required to disclose their Participation Status as part of their initial appointment, employment, commencement of the contract and registration/application processes and when Board Members, Employees, and FDRs receive notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

The Compliance Officer, or his/her Designee, will review reports from Employees responsible for conducting the Participation Status Reviews to ensure Employees record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the Compliance Officer, or his/her Designee, of affirmative findings of a person, or entity's, failure to meet the Participation Status Review requirements. If CalOptima learns that any prospective, or current, Board Member, Employee, or FDR has been proposed for Exclusion, Excluded or Precluded, CalOptima will promptly remove him/her/the FDR from CalOptima's Programs consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of

their suspension, Exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the CMS Preclusion List, consistent with regulatory guidance, applicable policies, and/or contract terms. The Compliance Officer, or his/her Designee, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII. RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's Compliance Program and/or FWA issues, the Compliance Officer, or his/her Designee, shall, upon promptly verifying the facts related to the violation or likely violation, notify the Compliance Committee, as appropriate. The Compliance Committee (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, Sanctions, termination of any agreement and/or any other corrective action consistent with applicable Policies and Procedures, subject to consultation with legal counsel and/or notifying the Governing Body, as appropriate;
- Implementing education and training programs for Board Members, Employees, and/or FDRs, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's Compliance Plan, Code of Conduct, and/or relevant Policies and Procedures to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the Compliance Officer and the Compliance Committee to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable Policies and Procedures after considering such recommendations. The Compliance Officer, or his/her Designee, may Monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning Fraud schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

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activity indicates that Fraud may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a Fraud alert is received, CalOptima shall review its Delegation agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the Delegation agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a Fraud alert. With the issuance of a Fraud alert, CMS places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party need to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged Fraud scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes Member complaints, DHCS Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal and/or State Health Care Programs requirements. CalOptima shall also maintain files that contain documented warnings (e.g., Fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, DHCS, CMS, and CMS' Designee, regarding Monitoring of FDRs within CalOptima's network that DHCS, or CMS, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent FWA within a CalOptima Program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of FWA activity. CalOptima shall assess all FDRs for potential Overpayments when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return Overpayments consistent with applicable laws and regulatory guidance.

As required, CalOptima and/or the FDR shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of Overpayment determinations to Regulatory Agencies, as required by law.

When applicable, CalOptima shall return Overpayments made to CalOptima, consistent with applicable state and federal laws and regulatory guidance.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima's Compliance Program. FWA activities are implemented and overseen by CalOptima's Compliance Officer, or his/her Designee, in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for FWA investigations. The Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Compliance Committee, CEO, the CalOptima Board, and Regulatory Agencies.

CalOptima utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Programs is appropriately delivered to Members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

I.FWA TRAINING

As detailed above, FWA training is provided to all Board Members and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. FDRs are also required to complete FWA training, as described above. CalOptima's FWA training provides guidance to Board Members, Employees, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Examples of the most common types of Member FWA (see Appendix B, attached hereto and incorporated herein) and FDR FWA (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Programs (e.g., suspicious activities suggesting CalOptima Members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the CalOptima Programs, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average Member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for FDRs, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima's requirement to train Employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima shall provide Board Members, Employees, FDRs, and Members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with CalOptima internal departments, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of FWA. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. Members, FDRs, Employees, law enforcement and Regulatory Agencies, and others may contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect FWA include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record Audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and Monitoring Activities;
- Monitoring external health care FWA cases and determining if CalOptima's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and Audits.

b. Data Analytics

CalOptima uses technology and data analysis to reduce FWA externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect FDRs based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, OneCare Connect, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review

of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or Audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by Members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected FWA. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/ or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will

be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a Member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a Member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the Member/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA database and a report is generated and submitted to the Compliance Officer, Compliance Committee, and CEO.

III.FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU, or a Designee, interviews the individual who reported the FWA, affected Members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership, as necessary;
- Review of Member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Compliance Officer and Compliance Committee. If a CalOptima internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused Audits, additional investigation, continued Monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential

FWA issue has been identified, the SIU will track and trend the FWA allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's Policies and Procedures, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima Policies and Procedures, CalOptima shall take appropriate disciplinary, or corrective, action against Board Members, Employees, and/or FDRs related to validated instances of FWA. CalOptima will also assess FDRs for potential Overpayments when reviewing and undertaking corrective actions. Corrective actions will be Monitored by the Compliance Committee, and progressive discipline will be Monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial Sanctions, regulatory reporting, Corrective Action Plans, or termination of the Delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

b. Referral to Enforcement Agencies

CalOptima's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) working days to DHCS after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare, OneCare Connect, or PACE programs.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Members; and/or
- Schemes with large financial risk to CalOptima, or its Members.

IV.ANNUAL FWA EVALUATION

CalOptima's Compliance Committee shall periodically review and evaluate the FWA activities and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Compliance Plan, and other input from applicable sources.

a. Retention of Records

CalOptima shall maintain reports and summaries of FWA activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of Member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of FWA investigations in a secure and confidential manner, regardless of the outcome of an investigation.

b. Confidentiality

CalOptima and its FDRs shall maintain all information associated with suspected, or actual, FWA in confidential files, which may only be released in accordance with applicable laws and CalOptima Policies and Procedures. All participants and attendees of CalOptima's Quality Improvement Committee, Compliance Committee, and respective subcommittees shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the Compliance Program, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the Compliance Program against the elements of an effective Compliance Program as recommended by OIG and required by CMS regulations. The following areas will be reviewed:

- Policies and Procedures;
- Compliance Officer and Compliance Committee;
- Training and education of Board Members, Employees, and FDRs;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal Monitoring and Auditing;
- Delegation oversight;
- Exclusion and Preclusion screening process; and
- Prompt responses to detected offenses.

The Compliance Program will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with Executive Staff and Management, the Compliance Committee, and the CalOptima Board. Updates to the Compliance Program will be based on the results of the evaluation and will be referred to the CalOptima Board for review and approval.

I.PRIVILEGED FILES AND DOCUMENT RETENTION

a. Privileged Files

All privileged files shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the Compliance Officer, CalOptima legal counsel, and the Compliance Committee, where appropriate, shall have access to its contents. All materials in the privileged file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. The privileged file shall contain the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the Compliance Officer;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning FDR delegation agreement interpretations and remedies available to CalOptima.

b. Document Retention

CalOptima shall retain contracts, books, documents, records, financial statements, and other data, as defined in Title 42, Code of Federal Regulations, Sections 438.5(c), 438.604, 606, 608, and 610, for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract (except for privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary).

CalOptima shall maintain the documentation required by HIPAA for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) Policies and Procedures (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by HIPAA; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under HIPAA; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the Fraud, Waste, and Abuse laws. CalOptima is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from

Principle	Standard
	relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure

Principle	Standard
	effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its Health Networks and third-party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and

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	other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.
Public Integrity CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.

Principle	Standard
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies,

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third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or

Principle	Standard
	other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members,	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not

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providers, and other persons is fundamental to fulfilling its mission and goals.	unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will Monitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their Exclusion or Preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the

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	delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a Supervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below.

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	Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by Health Networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

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Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight Audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight Audits.

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FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.
P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight Audit; report by regulatory body; hotline.
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight Audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight Audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

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E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit" or "Auditing") means a formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and may require one (1) of several acknowledged certifications..

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima Members" or "Members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered

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by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive Staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees, and FDRs comply with applicable law and ethical standards.

Compliance Risk Assessment ("CRA") A tool utilized to stratify level of risk (high, medium, low) based upon Audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or Monitoring Activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular

functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is a person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Downstream Entity ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima program benefit, below the level of the arrangement between CalOptima and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or **Employees** ("Employee" or "Employees") means any and all employees of CalOptima, including all Executive Staff, Management, officers, managers, Supervisors and other employed personnel, as well as temporary employees and volunteers.

Exclusion ("Exclusion" or "Excluded") means suspension, exclusion, or debarment from participation in federal and/or state health care programs.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

Executive Staff ("Executive Staff") means an employee whose position title is Chief, or Executive Director of one (1) or more departments.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State Health Care Programs") means any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a member under a CalOptima program.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

General Services Administration ("GSA") **System for Award Management** ("SAM") is a type of federal government exclusion database and contains the list of Excluded Parties List System (GSA-EPLS). The EPLS consists of federal contractors who have been debarred, Sanctioned, or excluded due to government contract issues or fraud. The database is usually updated on a monthly basis.

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network ("Health Network" or "Health Networks") means the contracted Health Networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Immediate Corrective Action Plan ("ICAP") means the result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Management ("Management") means any employee whose position title is Director, Senior Manager, Manager, or Supervisor of one (1) or more departments.

Medi-Cal Suspended & Ineligible ("S&I") **Provider List** is a list of suspended and ineligible providers that is maintained by DHCS in the Medi-Cal Provider Manual. The list is updated monthly and available online and in print from DHCS.

Medicare Secondary Payer (MSP) Vendor means third-party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare or OneCare Connect for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Monitoring Activities ("Monitoring") means regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Multipurpose Senior Services Program ("MSSP") is a program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Office of Inspector General List of Excluded Individuals and Entities ("OIG LEIE") is an exclusion list and contains individuals and/or entities that have been excluded from participation in federal healthcare programs such as Medicare and Medicaid. This list is usually updated on a monthly basis.

OneCare ("OneCare") is a Medicare Advantage Health Maintenance Organization (HMO) plan offered by CalOptima to provide Medicare covered benefits to Members.

OneCare Connect ("OneCare Connect") is a Medicare-Medicaid health plan offered by CalOptima that contracts with both Medicare and Medi-Cal to provide covered benefits of both programs to Members.

Overpayment ("Overpayment") means a payment disbursed in excess of amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating Providers and Suppliers ("Participating Providers and Suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its Health Networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the Health Networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board Members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded, or otherwise ineligible to participate in Federal and/or State health care programs.

Personally Identifiable Information ("PII") means any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmacy Benefit Manager ("PBM") means an entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Program of All-Inclusive Care for the Elderly ("PACE") is a long-term comprehensive health care program that helps older adults to 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.

Preclusion ("Precluded" or "Preclusion List") is a type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Protected Health Information ("PHI") refers to the 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Readiness Assessment ("Readiness Assessment") is an assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CalOptima. The assessment determines the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional area requirements, as determined by CalOptima.

Regulatory Agencies ("Regulatory Agencies") include, but are not limited to: Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

Related Entity ("Related Entity") means any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Sanction ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

Seniors and Persons with Disabilities ("SPD") means Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third-Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy:	HH.2021Δ
Title:	**Exclusion and Preclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	
Effective Date:	05/01/2012
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy outlines a process for verifying and Monitoring* the eligibility of Employees (permanent, temporary, volunteer, and as-needed Employees), Members of the Governing Body, First Tier, Downstream, and Related Entities (FDRs), non-contracted Providers, and vendors to participate in CalOptima federal and/or state health care programs through state and federal exclusions, Preclusion, and ineligible person/entity lists.

II. POLICY

A. CalOptima shall ensure all Employees, Members of the Governing Body, FDRs, non-contracted Providers, and vendors are eligible to participate in CalOptima federal and/or state health care programs, and shall be responsible for:

1. Requiring an Employee, Member of the Governing Body, FDR, non-contracted Provider or vendor to disclose and report pending suspensions, exclusions, Preclusions, or debarments, of the Employee, Member of the Governing Body, FDR, Providers, or vendor;

2. Conducting the initial eligibility verification of an Employee, Member of the Governing Body, FDR, non-contracted Provider, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an Employee, Member of the Governing Body, FDR, non-contractor Providers, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

B. CalOptima shall not employ individuals, or contract with individuals or entities that are determined to be suspended, debarred, precluded or Excluded from participation in federal or state health care programs.

C. CalOptima shall not reimburse, or make payment for services provided under the medical direction or on the prescription of an Excluded person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, precluded or Excluded from participation in federal or state health care programs.

D. CalOptima will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor for

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

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all CalOptima programs, or the appointment of a Member of the Governing Body, if such individual or entity is verified to be suspended, debarred, precluded or Excluded from participation in federal or state health care programs.

E. CalOptima shall utilize state and federal Preclusion, exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider or vendor and shall maintain a record of completion.

F. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion.

G. In the event a CalOptima FDR, or vendor identifies its employees and/or Downstream Entities on an Exclusion, Preclusion, and/or ineligible person/entity list, the FDR or vendor must immediately notify CalOptima of the identified ineligible person/entity. CalOptima in its sole discretion will determine whether it is appropriate to immediately remove/terminate the identified person/entity from furnishing items and services for CalOptima programs and/or terminate the applicable FDR or vendor contract.

H. The Office of Compliance may Audit CalOptima departments responsible for exclusion and Preclusion activities, as necessary.

III. PROCEDURE

A. Initial Verification

1. Prior to hiring an Employee, having an individual become a Member of the Governing Body or a CalOptima committee, or contracting with an FDR or vendor, or approving payment to a non-contracted Provider the responsible department identified in the chart in Section III.B.2. of this Policy shall verify that the individual or entity is not Excluded or Precluded by reviewing the Monitoring sources to retrieve verification and eligibility data, including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medi-Cal's Suspended and Ineligible (S&I) list;

   c. CMS Preclusion List;

   d. OIG Exclusions Database (OIG LEIE Database); and

   e. Other Monitoring sources as identified in CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

B. Evidence of Verification

1. CalOptima shall utilize state and federal Preclusion, Exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider or vendor and shall maintain a record of completion indicating, at minimum:

   a. The date of verification;

b. The Exclusion, Preclusion, and ineligible person/entity list source(s);

c. Verification results; and

d. The name of the person who conducted the verification.

2. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly Exclusions and Preclusions checks thereafter.

Group	Prior to contracting/hire, or payment ~~if~~ of a non-contracted Provider, CalOptima will verify through …	Monthly thereafter, CalOptima will verify through …
~~**Employees**~~	• ~~Human Resources~~	• ~~Human Resources~~
~~Members of the **Governing Body** (Board of Directors)~~	• ~~Human Resources~~	• ~~Human Resources~~
CalOptima Committees	• Human Resources	• Human Resources
~~Pharmacy Prescribers~~Employees	• ~~Pharmacy Benefit Manager~~Human Resources	• ~~Pharmacy Benefit Manager~~Human Resources
~~Pharmacy Network **Providers**~~	• ~~Pharmacy Benefit Manager~~	• ~~Pharmacy Benefit Manager~~
FDRs, Vendors (excluding Medical Providers and Health Networks)	• Vendor Management • PACE (PACE Vendors only)	• Regulatory Affairs & Compliance
Health Networks	• Contracting	• Regulatory Affairs & Compliance
Letter of Agreement (LOA)	• Quality/Credentialing • Utilization Management • PACE (PACE LOAs only)	• Quality/Credentialing • Regulatory Affairs & Compliance
Medical Group Practices, Physician Medical Groups	• Quality/Credentialing	• Quality/Credentialing • Regulatory Affairs & Compliance
Medical Providers, Practitioners, Health Delivery Organizations (HDOs)	• Quality/Credentialing (contracted) • Provider Data Management Services (non-contracted)	• Quality/Credentialing
~~Health Networks~~Members of the Governing Body (Board of Directors)	• ~~Contracting~~Human Resources	• ~~Regulatory Affairs & Compliance~~Human Resources
Non-Medical ~~Group Practices, physician medical groups, non-medical~~ Providers ~~and letter of agreements (LOAs)~~	• ~~Contracting~~Quality/Credentialing (MSSP Non-Medical Providers) • PACE (PACE Non-Medical Providers)	• ~~Quality/Credentialing~~ • Regulatory Affairs & Compliance
Pharmacy Network Providers	• Pharmacy Benefit Manager	• Pharmacy Benefit Manager
Pharmacy Prescribers	• Pharmacy Benefit Manager	• Pharmacy Benefit Manager

3. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities (as defined above) prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

    a. Date of verification;

    b. The Exclusion, Preclusion and ineligible person/entity list source(s);

    c. Verification results; and

    d. The name of the person who conducted the verification.

C. Monitoring

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor Employees, FDRs, non-contracted Providers, vendors, and Members of the Governing Body and committees by reviewing the Monitoring sources listed in s~~S~~ection III.A.1 of this Policy.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, ~~Section~~section 1001.1901, subsection (b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible, or Excluded, Employee, Member of the Governing Body or CalOptima committee, FDR, non-contracted Provider, or vendor; or at the medical direction or on the prescription of a physician or an authorized individual who is Excluded when the person furnishing such item or service knew, or had reason to know, of the Exclusion. The payment prohibition applies regardless of whether the Excluded individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs.

    a. The responsible department shall deem an Employee, Member of the Governing Body or committee, FDR, non-contracted Provider or vendor Excluded, or ineligible, if identified on one (1) or more Monitoring sources. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the Excluded, or ineligible, individual, or entity.

    b. The responsible department should refer the matter to the Office of Compliance for further investigation. As appropriate, the Office of Compliance may refer issues regarding the Excluded individual or entity to Legal Affairs for further action.

    c. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the contractual relationship for all CalOptima programs with a FDR, or vendor, or the appointment of a Member of the Governing Body, if such person, or entity, is determined to be Excluded. If the report identifies the removal of a suspended, Excluded, or terminated non-contracted Provider or FDR from CalOptima's Provider network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the Provider or FDR is no longer receiving payments in connection with the Medi-Cal program.

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d. In the event, that an Employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Employee.

e. CalOptima may recoup monies paid to the Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor while Excluded or Precluded. Exclusion and Preclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, the Office of Compliance may refer issues regarding the Excluded or Precluded person to Legal Affairs for further action.

E. Actions Based on Discovery of Preclusion

1. In accordance with Title 42, Code of Federal Regulations, ~~s~~Sections 422.222, 422.224, 423.100, 423.120(c)(6), for Precluded Providers, FDRs, or vendors, CalOptima may not reimburse or make payment for claims (i.e., for covered items or services) or prescriptions with any individual or entities on the CMS Preclusion List, including for emergency or urgent care circumstances.

a. The responsible department shall deem an FDR, non-contracted Provider, or vendor Precluded if identified on the CMS Preclusion List. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the Precluded FDR, non-contracted Provider, or vendor. CalOptima is also to notify the Health Networks to remove any contracted Provider and any contracted pharmacy found on the CMS Preclusion List from their network as soon as possible.

b. CalOptima shall notify Precluded FDRs, non-contracted Providers or vendors in writing that they can no longer treat Members and notify all impacted Members, including Members assigned to Health Networks, in writing who have received care or prescription from the Precluded FDR, non-contracted Provider, or vendor in the last twelve (12) months as soon as possible, but no later than thirty (30) calendar days after the date the FDR, non-contracted Provider, or vendor was Precluded. CalOptima will also remove the FDR or vendor from the Provider Directory no later than thirty (30) calendar days after the date the FDR or vendor was Precluded.

c. CalOptima will have thirty (30) days to review the CMS Preclusion List and notify in writing impacted Members, including Members assigned to Health Networks, no later than thirty (30) calendar days from the posting of the updated list. Members should be given at least sixty (60) calendar days advance notice before payment denials and claims rejections begin.

d. CalOptima should not deny payments and/or reject claims earlier than ninety (90) calendar days after publication of the associated Preclusion list.

e. For FDRs, non-contracted Providers, or vendors identified on both the Exclusion sources and the CMS Preclusion List, CalOptima's processes for an Excluded individual or entity supersedes those of a Precluded individual or entity.

F. FDRs and Vendors

1. If CalOptima intends to deny a prospective FDR or vendor participation in CalOptima program(s), or terminate an existing FDR's or vendor's contract, on the basis of an Exclusion or Preclusion, it shall notify the FDR or vendor, in writing, noting the reason for denial. The prospective or existing FDR or vendor may contest the denial if they feel there is an error or

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inappropriate Exclusion. If CalOptima determines that there is an inappropriate Exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If a previously Excluded or Precluded FDR or vendor has been re-instated by a Monitoring source listed on this Policy and is now in good standing and able to participate in CalOptima federal and/or state health care programs, the FDR or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify reinstatement into federally funded health care programs. In addition, the FDR or vendor will undergo re-processing through contracting and/or Credentialing.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Medicaid Program Integrity Manual, Revised ~~2011~~June 19, 2020
J. Medicare Program Integrity Manual, Chapter 4. Revised ~~June 9, 2017~~July 27, 2020
K. Sections 1128 and 156 of the Social Security Act
L. Title 42, Code of Federal Regulations (CFR.), §1001.1901
M. Title 42, United States Code (US.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
N. Title 42, Code of Federal Regulations, §§422.222, 422.224, 423.100, and 423.120(c)(6)
O. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Exclusion Monitoring	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	~~Any~~For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary ~~who is~~ enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
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.

Term	Definition
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

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Policy:	HH.2021Δ
Title:	**Exclusion and Preclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	
Effective Date:	05/01/2012
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy outlines a process for verifying and Monitoring the eligibility of Employees (permanent, temporary, volunteer, and as-needed Employees), Members of the Governing Body, First Tier, Downstream, and Related Entities (FDRs), non-contracted Providers, and vendors to participate in CalOptima federal and/or state health care programs through state and federal exclusions, Preclusion, and ineligible person/entity lists.

II. POLICY

A. CalOptima shall ensure all Employees, Members of the Governing Body, FDRs, non-contracted Providers, and vendors are eligible to participate in CalOptima federal and/or state health care programs, and shall be responsible for:

1. Requiring an Employee, Member of the Governing Body, FDR, non-contracted Provider or vendor to disclose and report pending suspensions, exclusions, Preclusions, or debarments, of the Employee, Member of the Governing Body, FDR, Providers, or vendor;

2. Conducting the initial eligibility verification of an Employee, Member of the Governing Body, FDR, non-contracted Provider, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an Employee, Member of the Governing Body, FDR, non-contractor Providers, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

B. CalOptima shall not employ individuals, or contract with individuals or entities that are determined to be suspended, debarred, precluded or Excluded from participation in federal or state health care programs.

C. CalOptima shall not reimburse, or make payment for services provided under the medical direction or on the prescription of an Excluded person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, precluded or Excluded from participation in federal or state health care programs.

D. CalOptima will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor for

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all CalOptima programs, or the appointment of a Member of the Governing Body, if such individual or entity is verified to be suspended, debarred, precluded or Excluded from participation in federal or state health care programs.

E. CalOptima shall utilize state and federal Preclusion, exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider or vendor and shall maintain a record of completion.

F. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion.

G. In the event a CalOptima FDR, or vendor identifies its employees and/or Downstream Entities on an Exclusion, Preclusion, and/or ineligible person/entity list, the FDR or vendor must immediately notify CalOptima of the identified ineligible person/entity. CalOptima in its sole discretion will determine whether it is appropriate to immediately remove/terminate the identified person/entity from furnishing items and services for CalOptima programs and/or terminate the applicable FDR or vendor contract.

H. The Office of Compliance may Audit CalOptima departments responsible for exclusion and Preclusion activities, as necessary.

III. PROCEDURE

A. Initial Verification

1. Prior to hiring an Employee, having an individual become a Member of the Governing Body or a CalOptima committee, or contracting with an FDR or vendor, or approving payment to a non-contracted Provider the responsible department identified in the chart in Section III.B.2. of this Policy shall verify that the individual or entity is not Excluded or Precluded by reviewing the Monitoring sources to retrieve verification and eligibility data, including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medi-Cal's Suspended and Ineligible (S&I) list;

   c. CMS Preclusion List;

   d. OIG Exclusions Database (OIG LEIE Database); and

   e. Other Monitoring sources as identified in CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

B. Evidence of Verification

1. CalOptima shall utilize state and federal Preclusion, Exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider or vendor and shall maintain a record of completion indicating, at minimum:

   a. The date of verification;

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b. The Exclusion, Preclusion, and ineligible person/entity list source(s);

c. Verification results; and

d. The name of the person who conducted the verification.

2. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly Exclusions and Preclusions checks thereafter.

Group	Prior to contracting/hire, or payment of a non-contracted Provider, CalOptima will verify through …	Monthly thereafter, CalOptima will verify through …
CalOptima Committees	• Human Resources	• Human Resources
Employees	• Human Resources	• Human Resources
FDRs, Vendors (excluding Medical Providers and Health Networks)	• Vendor Management • PACE (PACE Vendors only)	• Regulatory Affairs & Compliance
Health Networks	• Contracting	• Regulatory Affairs & Compliance
Letter of Agreement (LOA)	• Quality/Credentialing • Utilization Management • PACE (PACE LOAs only)	• Quality/Credentialing • Regulatory Affairs & Compliance
Medical Group Practices, Physician Medical Groups	• Quality/Credentialing	• Quality/Credentialing • Regulatory Affairs & Compliance
Medical Providers, Practitioners, Health Delivery Organizations (HDOs)	• Quality/Credentialing (contracted) • Provider Data Management Services (non-contracted)	• Quality/Credentialing
Members of the Governing Body (Board of Directors)	• Human Resources	• Human Resources
Non-Medical Providers	• Quality/Credentialing (MSSP Non-Medical Providers) • PACE (PACE Non-Medical Providers)	• Regulatory Affairs & Compliance
Pharmacy Network Providers	• Pharmacy Benefit Manager	• Pharmacy Benefit Manager
Pharmacy Prescribers	• Pharmacy Benefit Manager	• Pharmacy Benefit Manager

3. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities (as defined above) prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

a. Date of verification;

b. The Exclusion, Preclusion and ineligible person/entity list source(s);

c. Verification results; and

d. The name of the person who conducted the verification.

C. Monitoring

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor Employees, FDRs, non-contracted Providers, vendors, and Members of the Governing Body and committees by reviewing the Monitoring sources listed in section III.A.1 of this Policy.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, section 1001.1901, subsection (b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible, or Excluded, Employee, Member of the Governing Body or CalOptima committee, FDR, non-contracted Provider, or vendor; or at the medical direction or on the prescription of a physician or an authorized individual who is Excluded when the person furnishing such item or service knew, or had reason to know, of the Exclusion. The payment prohibition applies regardless of whether the Excluded individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs.

a. The responsible department shall deem an Employee, Member of the Governing Body or committee, FDR, non-contracted Provider or vendor Excluded, or ineligible, if identified on one (1) or more Monitoring sources. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the Excluded, or ineligible, individual, or entity.

b. The responsible department should refer the matter to the Office of Compliance for further investigation. As appropriate, the Office of Compliance may refer issues regarding the Excluded individual or entity to Legal Affairs for further action.

c. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the contractual relationship for all CalOptima programs with a FDR, or vendor, or the appointment of a Member of the Governing Body, if such person, or entity, is determined to be Excluded. If the report identifies the removal of a suspended, Excluded, or terminated non-contracted Provider or FDR from CalOptima's Provider network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the Provider or FDR is no longer receiving payments in connection with the Medi-Cal program.

d. In the event, that an Employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Employee.

e. CalOptima may recoup monies paid to the Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor while Excluded or Precluded. Exclusion and Preclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, the Office of Compliance may refer issues regarding the Excluded or Precluded person to Legal Affairs for further action.

E. Actions Based on Discovery of Preclusion

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1. In accordance with Title 42, Code of Federal Regulations, sections 422.222, 422.224, 423.100, 423.120(c)(6), for Precluded Providers, FDRs, or vendors, CalOptima may not reimburse or make payment for claims (i.e., for covered items or services) or prescriptions with any individual or entities on the CMS Preclusion List, including for emergency or urgent care circumstances.

    a. The responsible department shall deem an FDR, non-contracted Provider, or vendor Precluded if identified on the CMS Preclusion List. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the Precluded FDR, non-contracted Provider, or vendor. CalOptima is also to notify the Health Networks to remove any contracted Provider and any contracted pharmacy found on the CMS Preclusion List from their network as soon as possible.

    b. CalOptima shall notify Precluded FDRs, non-contracted Providers or vendors in writing that they can no longer treat Members and notify all impacted Members, including Members assigned to Health Networks, in writing who have received care or prescription from the Precluded FDR, non-contracted Provider, or vendor in the last twelve (12) months as soon as possible, but no later than thirty (30) calendar days after the date the FDR, non-contracted Provider, or vendor was Precluded. CalOptima will also remove the FDR or vendor from the Provider Directory no later than thirty (30) calendar days after the date the FDR or vendor was Precluded.

    c. CalOptima will have thirty (30) days to review the CMS Preclusion List and notify in writing impacted Members, including Members assigned to Health Networks, no later than thirty (30) calendar days from the posting of the updated list. Members should be given at least sixty (60) calendar days advance notice before payment denials and claims rejections begin.

    d. CalOptima should not deny payments and/or reject claims earlier than ninety (90) calendar days after publication of the associated Preclusion list.

    e. For FDRs, non-contracted Providers, or vendors identified on both the Exclusion sources and the CMS Preclusion List, CalOptima's processes for an Excluded individual or entity supersedes those of a Precluded individual or entity.

F. FDRs and Vendors

1. If CalOptima intends to deny a prospective FDR or vendor participation in CalOptima program(s), or terminate an existing FDR's or vendor's contract, on the basis of an Exclusion or Preclusion, it shall notify the FDR or vendor, in writing, noting the reason for denial. The prospective or existing FDR or vendor may contest the denial if they feel there is an error or inappropriate Exclusion. If CalOptima determines that there is an inappropriate Exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If a previously Excluded or Precluded FDR or vendor has been re-instated by a Monitoring source listed on this Policy and is now in good standing and able to participate in CalOptima federal and/or state health care programs, the FDR or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify reinstatement into federally funded health care programs. In addition, the FDR or vendor will undergo re-processing through contracting and/or Credentialing.

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, Chapter 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Medicaid Program Integrity Manual, Revised June 19, 2020
J. Medicare Program Integrity Manual, Chapter 4. Revised July 27, 2020
K. Sections 1128 and 156 of the Social Security Act
L. Title 42, Code of Federal Regulations (CFR.), §1001.1901
M. Title 42, United States Code (US.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
N. Title 42, Code of Federal Regulations, §§422.222, 422.224, 423.100, and 423.120(c)(6)
O. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Exclusion Monitoring	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
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.

Term	Definition
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

1

Policy:	HH.2023Δ
Title:	**Compliance Training**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy describes CalOptima's compliance and Fraud, Waste, and Abuse (FWA)* education and training requirements for Employees, members of the Governing Body, and First Tier, Downstream, and Related Entities (FDRs).

II. POLICY

A. All CalOptima Employees, members of the Governing Body, and FDRs must successfully complete the required Compliance and FWA Training Program within ninety (90) calendar days of hire, or contracting, and annually thereafter.

B. All CalOptima Employees and members of the Governing Body shall complete the knowledge verification for the applicable Compliance and FWA Training Program with a score of eighty percent (80%) or greater.

C. When reviewing and establishing the content of Compliance and FWA Training Program, the Compliance Officer may consider applicable statutes, regulations, regulator contractual requirements, and regulatory guidance. The following are examples of topics the general Compliance and FWA Training Program shall communicate:

1. A description of the Compliance Program, including a review of compliance policies and procedures, the Code of Conduct, and CalOptima's commitment to business ethics and compliance with all CalOptima program requirements;

2. An overview of how to ask compliance questions, request compliance clarification, or report suspected, or detected, non-compliance. Training should emphasize Confidentiality, anonymity, and non-Retaliation for reporting compliance related questions, or reports of suspected, or detected, non-compliance, or potential FWA;

3. The requirement to report to CalOptima actual or suspected program non-compliance, or potential FWA;

4. Scenarios of reportable non-compliance that an Employee might observe;

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5. A review of the disciplinary guidelines for non-compliant or fraudulent behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated, or when knowledge of a possible violation is not reported;

6. Discussion of attendance and participation in Compliance and FWA Training Programs as a condition of continued employment and a criterion to be included in Employee evaluations;

7. A review of policies related to contracting with the government, such as the laws addressing gifts and gratuities for government Employees;

8. A review of potential conflicts of interest and CalOptima's system for disclosure of conflicts of interest;

9. An overview of HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the Confidentiality of Protected Health Information;

10. An overview of the Monitoring and Auditing process; and

11. A review of the laws that govern Employee conduct in the CalOptima programs.

D. CalOptima Employees, members of the Governing Body, as well as FDR Employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive FWA training within ninety (90) calendar days of initial hiring (or contracting in the case of FDRs), and annually thereafter. Additionally, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function (e.g., pharmacist, statistician, customer service, etc.). Training may be provided:

1. Upon appointment to a new job function;

2. When requirements change;

3. When Employees are found to be non-compliant;

4. As a corrective action to address a non-compliance issue; and

5. When an Employee works in an area implicated in past FWA.

E. Topics that may be addressed in FWA training include, but are not limited to:

1. Laws and regulations related to Medicare Part C and Part D FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA/HITECH, etc.);

2. Obligations of FDRs to have appropriate policies and procedures to address FWA;

3. Processes for CalOptima Employees, members of the Governing Body, FDRs, and FDR Employees to report suspected FWA to CalOptima (or, for FDR Employees, either to CalOptima directly, or to their employers who then must report it to CalOptima);

4. Protections for CalOptima and FDR Employees who report suspected FWA; and

5. Types of FWA that can occur in the settings in which CalOptima and FDR Employees work. All CalOptima FDRs shall receive CalOptima Compliance and FWA Training Program and CalOptima's Code of Conduct training upon contracting. Additionally, training modules are provided through the CalOptima vendor and Provider website with updates provided to FDRs and annually thereafter.

F. FDRs who have met the FWA (as per Chapter 21, Section 50.3 of the Medicare Managed Care Manual) training and education certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are NOT exempt from the general compliance training requirement.

G. Documentation of Compliance with Training

1. CalOptima Employees, members of the Governing Body, FDRs, and FDR Employees, who are performing services on behalf of CalOptima shall successfully complete all required Compliance training modules.

2. Failure to successfully complete all required Compliance training may lead to disciplinary action (up to and including termination), Corrective Action Plan requirements, and/or Sanctions, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan. CalOptima Employees, members of the Governing Body, and FDRs are expected to inform CalOptima immediately in the event of any failure to comply with training requirements. For CalOptima Employees and members of the Governing Body, the Human Resources (HR) Training Unit has a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CalOptima system access.

3. The Office of Compliance is responsible for Monitoring and Auditing the compliance of Employees, members of the Governing Body, and FDRs with the Compliance and FWA training and education requirements.

4. FDRs shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further corrective actions.

H. Training Document Retention.

1. CalOptima and FDRs shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:

a. Attendance;

b. Topic;

c. Certificates of Completion;

d. FDR Attestations;

e. Test scores; and

f. Tests administered to Employees.

IV. PROCEDURE

A. Distributing Training for Existing Employees and Members of the Governing Body

1. On an annual basis, the HR Training Unit shall communicate to all Employees and members of the Governing Body that an updated Compliance training is available and must be successfully completed within sixty (60) calendar days.

2. Upon completion, Employees and members of the Governing Body can access a learner transcript confirming successful completion. The transcript will include the training title and completion date. HR, via the HR Training Unit, is responsible for retaining evidence of an Employee's and members of the Governing Body's successful completion of all Compliance training modules.

B. Distributing Training for New Employees and Members of the Governing Body

1. Upon hire, the HR Training Unit shall provide each new Employee and member(s) of the Governing Body with instructions to complete the Compliance Training.

2. The HR Training Unit shall create a system generated report that identifies those who fail to comply within the mandated time frames. Non-compliance will result in revoking system access.

C. Distributing Training to FDRs

1. The Office of Compliance shall ensure the training is uploaded and available on the CalOptima vendor and Provider website.

2. Upon contracting, the Office of Compliance shall distribute an FDR Compliance Package composed of compliance documents, including the CalOptima Compliance and FWA Training, CalOptima's Code of Conduct, FWA Plan, and an FDR Attestation that confirms the required Compliance training is completed by FDRs and their Employees within ninety (90) calendar days of hire and at least annually thereafter.

3. Annually, the Office of Compliance shall distribute and Monitor receipt of updated attestation to all FDRs for execution.

4. When there are updates to compliance training materials and/or related policies and procedures, the Office of Compliance shall communicate updates to all FDRs with instructions to access the CalOptima vendor and Provider website to retrieve them.

V. ATTACHMENT(S)

A. FDR Compliance Attestation

VI. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services (DHCS) for Cal MediConnect

~~D.~~E. CalOptima PACE Program Agreement
~~E.~~F. CalOptima Policy HH.2002Δ: Sanctions
~~F.~~G. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~G.~~H. CalOptima Policy HH.2028Δ: Code of Conduct
~~H.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services (DHCS) for Cal MediConnect~~
I. Medicare Managed Care Manual, Chapter 21
J. Medicare Prescription Drug Benefit Manual, Chapter 9
K. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)(A) and (D)
L. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(A) and (D)
M. Title 42, Code of Federal Regulations (C.F.R.), §438.608
N. Title 42, Code of Federal Regulations (C.F.R.), §455.2
O. "Update—Reducing the Burden of the Compliance Program Training Requirements," Health Plan Management System (HPMS) Memorandum, Issued 7/17/2015
P. "Additional Guidance -- Compliance Program Training Requirements and Audit Process Update," Health Management System (HPMS) Memorandum, Issued 2/10/2016.
Q. Welfare and Institutions Code, §14043.1(a)

VII. REGULATORY AGENCY APPROVAL(S)

None to Date

VIII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

IX. REVIEW/REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	MA.9119	Compliance Training	OneCare
Revised	11/01/2014	MA.9119	Compliance Training	OneCare
Effective	09/01/2015	HH.2023	Compliance Training	Medi-Cal
Revised	09/01/2015	MA.9119	Compliance Training	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2023Δ	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9119	Compliance Training	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2023Δ	Compliance Training	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.2023Δ	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2023Δ	Compliance and FWA Training	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2023Δ	Compliance and FWA Training	Medi-Cal OneCare OneCare Connect PACE

X. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in; unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, Employees, contractors, and agents are required to adhere.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

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), 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/OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract and DHCS Contract. PACE: Medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	For the purposes of this policy, a~~A~~ny and all Employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ~~health maintenance organization~~Health Network, p~~P~~hysician ~~Medical Group~~group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.2023Δ
Title:	**Compliance Training**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima's compliance and Fraud, Waste, and Abuse (FWA) education and training requirements for Employees, members of the Governing Body, and First Tier, Downstream, and Related Entities (FDRs).

II. POLICY

A. All CalOptima Employees, members of the Governing Body, and FDRs must successfully complete the required Compliance and FWA Training Program within ninety (90) calendar days of hire, or contracting, and annually thereafter.

B. All CalOptima Employees and members of the Governing Body shall complete the knowledge verification for the applicable Compliance and FWA Training Program with a score of eighty percent (80%) or greater.

C. When reviewing and establishing the content of Compliance and FWA Training Program, the Compliance Officer may consider applicable statutes, regulations, regulator contractual requirements, and regulatory guidance. The following are examples of topics the general Compliance and FWA Training Program shall communicate:

1. A description of the Compliance Program, including a review of compliance policies and procedures, the Code of Conduct, and CalOptima's commitment to business ethics and compliance with all CalOptima program requirements;

2. An overview of how to ask compliance questions, request compliance clarification, or report suspected, or detected, non-compliance. Training should emphasize Confidentiality, anonymity, and non-Retaliation for reporting compliance related questions, or reports of suspected, or detected, non-compliance, or potential FWA;

3. The requirement to report to CalOptima actual or suspected program non-compliance, or potential FWA;

4. Scenarios of reportable non-compliance that an Employee might observe;

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5. A review of the disciplinary guidelines for non-compliant or fraudulent behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated, or when knowledge of a possible violation is not reported;

6. Discussion of attendance and participation in Compliance and FWA Training Programs as a condition of continued employment and a criterion to be included in Employee evaluations;

7. A review of policies related to contracting with the government, such as the laws addressing gifts and gratuities for government Employees;

8. A review of potential conflicts of interest and CalOptima's system for disclosure of conflicts of interest;

9. An overview of HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the Confidentiality of Protected Health Information;

10. An overview of the Monitoring and Auditing process; and

11. A review of the laws that govern Employee conduct in the CalOptima programs.

D. CalOptima Employees, members of the Governing Body, as well as FDR Employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive FWA training within ninety (90) calendar days of initial hiring (or contracting in the case of FDRs), and annually thereafter. Additionally, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function (e.g., pharmacist, statistician, customer service, etc.). Training may be provided:

1. Upon appointment to a new job function;

2. When requirements change;

3. When Employees are found to be non-compliant;

4. As a corrective action to address a non-compliance issue; and

5. When an Employee works in an area implicated in past FWA.

E. Topics that may be addressed in FWA training include, but are not limited to:

1. Laws and regulations related to Medicare Part C and Part D FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA/HITECH, etc.);

2. Obligations of FDRs to have appropriate policies and procedures to address FWA;

3. Processes for CalOptima Employees, members of the Governing Body, FDRs, and FDR Employees to report suspected FWA to CalOptima (or, for FDR Employees, either to CalOptima directly, or to their employers who then must report it to CalOptima);

4. Protections for CalOptima and FDR Employees who report suspected FWA; and

5. Types of FWA that can occur in the settings in which CalOptima and FDR Employees work. All CalOptima FDRs shall receive CalOptima Compliance and FWA Training Program and CalOptima's Code of Conduct training upon contracting. Additionally, training modules are provided through the CalOptima vendor and Provider website with updates provided to FDRs and annually thereafter.

F. FDRs who have met the FWA (as per Chapter 21, Section 50.3 of the Medicare Managed Care Manual) training and education certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are NOT exempt from the general compliance training requirement.

G. Documentation of Compliance with Training

1. CalOptima Employees, members of the Governing Body, FDRs, and FDR Employees, who are performing services on behalf of CalOptima shall successfully complete all required Compliance training modules.

2. Failure to successfully complete all required Compliance training may lead to disciplinary action (up to and including termination), Corrective Action Plan requirements, and/or Sanctions, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan. CalOptima Employees, members of the Governing Body, and FDRs are expected to inform CalOptima immediately in the event of any failure to comply with training requirements. For CalOptima Employees and members of the Governing Body, the Human Resources (HR) Training Unit has a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CalOptima system access.

3. The Office of Compliance is responsible for Monitoring and Auditing the compliance of Employees, members of the Governing Body, and FDRs with the Compliance and FWA training and education requirements.

4. FDRs shall provide annual attestations confirming completion of all Compliance training as stated in this policy. Failure to provide timely attestation will lead to further corrective actions.

H. Training Document Retention.

1. CalOptima and FDRs shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:

a. Attendance;

b. Topic;

c. Certificates of Completion;

d. FDR Attestations;

e. Test scores; and

f. Tests administered to Employees.

IV. PROCEDURE

A. Distributing Training for Existing Employees and Members of the Governing Body

1. On an annual basis, the HR Training Unit shall communicate to all Employees and members of the Governing Body that an updated Compliance training is available and must be successfully completed within sixty (60) calendar days.

2. Upon completion, Employees and members of the Governing Body can access a learner transcript confirming successful completion. The transcript will include the training title and completion date. HR, via the HR Training Unit, is responsible for retaining evidence of an Employee's and members of the Governing Body's successful completion of all Compliance training modules.

B. Distributing Training for New Employees and Members of the Governing Body

1. Upon hire, the HR Training Unit shall provide each new Employee and member(s) of the Governing Body with instructions to complete the Compliance Training.

2. The HR Training Unit shall create a system generated report that identifies those who fail to comply within the mandated time frames. Non-compliance will result in revoking system access.

C. Distributing Training to FDRs

1. The Office of Compliance shall ensure the training is uploaded and available on the CalOptima vendor and Provider website.

2. Upon contracting, the Office of Compliance shall distribute an FDR Compliance Package composed of compliance documents, including the CalOptima Compliance and FWA Training, CalOptima's Code of Conduct, FWA Plan, and an FDR Attestation that confirms the required Compliance training is completed by FDRs and their Employees within ninety (90) calendar days of hire and at least annually thereafter.

3. Annually, the Office of Compliance shall distribute and Monitor receipt of updated attestation to all FDRs for execution.

4. When there are updates to compliance training materials and/or related policies and procedures, the Office of Compliance shall communicate updates to all FDRs with instructions to access the CalOptima vendor and Provider website to retrieve them.

V. ATTACHMENT(S)

A. FDR Compliance Attestation

VI. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services and the Department of Health Care Services (DHCS) for Cal MediConnect

E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy HH.2005Δ: Corrective Action Plan
H. CalOptima Policy HH.2028Δ: Code of Conduct
I. Medicare Managed Care Manual, Chapter 21
J. Medicare Prescription Drug Benefit Manual, Chapter 9
K. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)(A) and (D)
L. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(A) and (D)
M. Title 42, Code of Federal Regulations (C.F.R.), §438.608
N. Title 42, Code of Federal Regulations (C.F.R.), §455.2
O. "Update—Reducing the Burden of the Compliance Program Training Requirements," Health Plan Management System (HPMS) Memorandum, Issued 7/17/2015
P. "Additional Guidance -- Compliance Program Training Requirements and Audit Process Update," Health Management System (HPMS) Memorandum, Issued 2/10/2016.
Q. Welfare and Institutions Code, §14043.1(a)

VII. REGULATORY AGENCY APPROVAL(S)

None to Date

VIII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

IX. REVIEW/REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	MA.9119	Compliance Training	OneCare
Revised	11/01/2014	MA.9119	Compliance Training	OneCare
Effective	09/01/2015	HH.2023	Compliance Training	Medi-Cal
Revised	09/01/2015	MA.9119	Compliance Training	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2023Δ	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9119	Compliance Training	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2023Δ	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2023Δ	Compliance Training	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2019	HH.2023Δ	Compliance and FWA Training	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2023Δ	Compliance and FWA Training	Medi-Cal OneCare OneCare Connect PACE

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X. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in; unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, Employees, contractors, and agents are required to adhere.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

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), 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/OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract and DHCS Contract. PACE: Medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	For the purposes of this policy, any and all Employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.

Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).
Governing Body	The Board of Directors of CalOptima.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, Health Network, physician group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director~~Annie Phillips~~, 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for ~~(~~existing FDRs~~)~~, or sixty (60) calendar days for ~~(~~new FDRs~~)~~ of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐PACE ☐Medi-Cal ☐OneCare ~~HMO SNP~~ ☐~~PACE~~

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and Fraud, Waste and Abuse (FWA) Training**. Provide effective ~~Fraud, Waste and Abuse~~FWA training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use:

(Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records ~~per CMS retention requirement~~ as evidence of completed training)

☐ An internal training program that ~~meets~~ utilizes content available in the CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records ~~per CMS retention requirement~~as evidence of completed training)

Note: If selecting an internal training program that ~~meets~~ aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers ~~: (i) based on their job function~~ within the first ninety (90) days of hire and at least annually thereafter as ~~a~~ condition of appointment, employment or contracting. ~~requirements change; (iii) when such persons work in an area previously found to be non-compliant with program requirements or implicated in past misconduct.~~

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III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

(Select which applies to your organization):

☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct (https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks.aspx)

☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the {Medi-Cal Suspended and Ineligible Provider List} (S & I Medi-Cal), {Health and Human Services} (HHS), {Office of Inspector General} (OIG) List of Excluded Individuals & Entities list, {System for Award Management} (SAM)/{General Services Administration} (GSA) Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (hereafter "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII. **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature	Date
Name (Print)	Organization
Email (Print)	

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

~~Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days (existing FDRs) or sixty (60) calendar days (new FDRs) of the notice accompanying this form.~~

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐OneCare Connect ☐PACE ☐OneCare ~~HMO~~ ☐ Medi-Cal
Please check one of the following: ☐ Our Organization does not offshore any protected health information. **Please skip to Part V below.** ☐ Our Organization does offshore protected health information. **Please complete Offshore Subcontractor Attestation (Part I through Part V) below.**	
~~Are any administrative or other functions conducted on behalf of your Organization by entities located offshore? This shall include employees of your firm, subcontractors and any 3rd party subcontractors.~~ ~~If **NO**, please **complete Part I** and **Part VI** of this form:~~ ~~If **YES**, please skip Part I, and **complete Parts II–VI** of this form~~	~~☐Yes ☐No~~

~~**Part I — Our Firm is Not Using Offshore Subcontractors and/or Employees**~~	
~~**Attestation**~~	~~**Response**~~
~~**Offshore subcontractors**: Our Organization does not currently use offshore subcontractors.~~	~~☐Yes ☐No~~
~~**Offshore employees**: Our Organization does not employ workers who are located offshore.~~	~~☐Yes ☐No~~
~~Name of organization:~~	
~~Name of authorized person:~~	
~~Title:~~	
~~Signature:~~	
~~Date:~~	

Part I~~I~~ — Offshore Subcontractor Information	
Attestation	**Response**
~~**Offshore employees:**~~ Our Organization ~~does employ~~uses an offshore subcontractor or offshore staff to perform functions that support our contract with ~~CaOptima~~CalOptima. ~~workers who are located offshore~~	☐Yes ☐No
Offshore Subcontractor name:	
Offshore Subcontractor country:	

Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II~~I~~ — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor~~: and/or employee:~~	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's~~/employee's~~ objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part ~~IV~~ III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that ~~Medi-Cal and~~ Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore ~~subcontractor/employee~~ subcontracting arrangement prohibits ~~subcontractor/employee~~ subcontractor's access to ~~Medi-Cal and~~ Medicare data not associated with CalOptima's contract with the offshore subcontractor~~/employee~~.	☐Yes ☐No*
C. ~~Describe alternatives considered to avoid providing PHI, and why each alternative was rejected.~~ Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore ~~subcontractor/employee~~ subcontracting arrangement includes all required ~~DHCS (Department of Health Care Services) and/or CMS (Centers for Medicare & Medicaid Services)~~ Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)~~as stipulated within your contract with CalOptima~~	☐Yes ☐No*

~~*Explanation required for "no" response to Part IV items A to D above:~~

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. ~~Yo~~Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by ~~y~~our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. ~~Your~~ Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐Yes ☐No*
~~D. Our organization agrees to notify CalOptima at least 60 days in advance of our intent to use new offshore subcontractor(s) or before employing new offshore staff for a function CalOptima has asked us to perform.~~	~~☐Yes ☐No*~~

***~~Please provide explanation~~Explanation required for all "no" responses ~~to~~to Part III ~~if "no" select for Part V items A to D C and~~and Part IV ~~items A to C~~above:**

Part V~~I~~ — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx~~https://www.caloptima.org/en/Vendors/FDRCompllianceInformation.aspx~~

FDR COMPLIANCE ATTESTATION

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Which CalOptima program(s) does this form pertain to? Select all that apply:	☐ OneCare Connect ☐ PACE ☐ Medi-Cal ☐ OneCare

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and Fraud, Waste and Abuse (FWA) Training**. Provide effective FWA training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use:

(Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records as evidence of completed training)

☐ An internal training program that utilizes content available in the CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records as evidence of completed training)

Note: If selecting an internal training program that aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting.

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(Select which applies to your organization):

☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct (https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks.aspx)

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Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review to ensure they meet CMS's requirements.

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the Medi-Cal Suspended and Ineligible Provider List (S & I Medi-Cal), Health and Human Services (HHS), Office of Inspector General (OIG) List of Excluded Individuals & Entities list, System for Award Management (SAM)/General Services Administration (GSA) Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (hereafter "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima, confidentially and anonymously.

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VIII. **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature	Date
Name (Print)	Organization
Email (Print)	

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐OneCare Connect ☐PACE ☐OneCare ☐ Medi-Cal

Please check one of the following:

☐ Our Organization does not offshore any protected health information.
Please skip to Part V below.

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below.

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima.	☐Yes ☐No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor:	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐Yes ☐No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language. (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐Yes ☐No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐Yes ☐No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

Policy:	HH.2027Δ
Title:	**Annual Risk Assessment (~~Delegate~~FDR)**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy describes the Annual Risk Assessment process conducted by CalOptima's Audit & Oversight Department to identify ~~delegated~~ First Tier ~~Entities' (FTEs)*~~, Downstream, and Related Entities (FDRs) specific functional areas vulnerable to potential compliance risk. Such areas are documented in CalOptima's risk assessment, which will influence the development of CalOptima's ~~delegated FTE's~~FDR's audit and monitoring work plan.

II. POLICY

A. CalOptima maintains ultimate responsibility for adhering to and otherwise fully complying with its contract with the Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS). CalOptima is required to establish and implement an effective system of routine monitoring and identification of compliance risks.

B. At least annually, the Audit & Oversight Department is responsible for completing an Annual Risk Assessment to develop its ~~delegated FTE~~FDR audit and monitoring work plan that ensures CalOptima's regulatory obligations are met. In assessing risk, the Audit & Oversight Department shall consider the following:

1. Statutory, regulatory, and contractual standards;
2. CalOptima's policies and procedures;
3. Business impact on Member care; and
4. Past compliance issues.

C. CalOptima shall, through contract or appropriate written arrangements, require the ~~FTEs~~FDRs to conduct risk assessments, at least annually, and ongoing monitoring and audit of the Downstream Entities with which they contract to ensure compliance. CalOptima shall retain the right to conduct its own risk assessments and ongoing monitoring and audit of the Downstream Entities to ensure compliance.

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

D. The Audit & Oversight Department shall stay current with all regulatory communication and guidance from the Regulatory Agencies.

E. The Audit & Oversight Department shall present Annual Risk Assessment results and the proposed ~~FTE~~FDR audit and monitoring work plan to both the Audit & Oversight Committee (AOC) and the Compliance Committee for review and approval by the end of the calendar year to be effective for the following year.

III. PROCEDURE

A. The Audit & Oversight Department shall undertake a discovery process of the ~~FTEs~~FDRs, consisting of a document review to determine how regulatory, statutory, contractual, and CalOptima policy requirements are implemented; the operational effectiveness, and how the practices and the documentation support compliance. The analysis component of the Annual Risk Assessment is based on the evaluation of the ~~FTEs'~~FDRs' performance during the previous calendar year, including but not limited to ~~monthly~~ongoing monitoring ~~results, annual audit~~and auditing results and focused reviews when applicable.

1. In the event that the ~~FTE~~FDR is a new delegate, the Audit & Oversight Department shall audit the ~~First Tier Entity~~FDR to collect baseline data in accordance with CalOptima Policy GG.1619: Delegation Oversight.

B. The Audit & Oversight Department shall consider the following information as it applies to ~~FTEs~~FDRs, as part of the Annual Risk Assessment process:

1. A particular area identified by a Regulatory Agency as problematic through enforcement actions that may impact CalOptima, including but not limited to, National Committee for Quality Assurance (NCQA) status;

2. Regulatory audit findings;

3. CalOptima monitoring and audit findings;

4. Regulatory notices of non-compliance;

5. A completed questionnaire by the following CalOptima departments: (i) Regulatory Affairs and Compliance, (ii) Quality Improvement, (iii) Grievance and Appeals Resolution Services, (iv) Privacy, (v) Fraud, Waste & Abuse, and (vi) the business owner to provide knowledge of issues or trends being identified throughout CalOptima.

6. Accuracy of ~~delegate~~FDR encounter data~~,~~ submissions, coding, medical loss ratio (MLR) reported data, and other areas that may impact CalOptima payments (e.g., MLR, Hierarchical Condition Category (HCC) risk scores~~);~~), if applicable;

7. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliance area; and

8. Whether the First Tier Entities (FTEs) are applying appropriate compliance program requirements to the Downstream Entities with which they contract, conducting risk assessments, at least annually, and performing ongoing monitoring and auditing of such Downstream Entities to ensure compliance.

C. The Audit & Oversight Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment audits evaluating file reviews, data collected from ongoing monitoring ~~results, annual audit results, and~~and auditing results and number of CAPs issued during the review period.

1. The Audit & Oversight Department shall compile the data and rank the risks based on the greatest impact on delegated operations and quality health care delivery to CalOptima Members.

D. The Audit & Oversight Department shall present the ~~FTE~~FDR risk assessment results and proposed audit and monitoring work plan to the AOC and subsequently to the Compliance Committee for approval.

E. The Audit & Oversight Department shall re-evaluate the work plan based on internal changes for approval (e.g., staffing and organizational structure changes, audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, Regulatory Agency audit results, etc.).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

~~A. CalOptima Compliance Plan~~
~~B.~~A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~C.~~B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~A. ~~CalOptima Contract for Health Care Services~~
~~E.~~A. ~~CalOptima Policy GG.1619: Delegation Oversight~~
~~F.~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Contract for Health Care Services
E. CalOptima Compliance Plan
F. CalOptima Policy GG.1619: Delegation Oversight
G. Health Network Service Agreement
H. Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines
I. Prescription Drug Benefit Manual Chapter 9 - Compliance Program Guidelines
J. Title 42, Code of Federal Regulations (C.F.R.), §455.2
K. Welfare and Institutions Code §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	11/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	09/01/2015	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2027	Annual Risk Assessment	Medi-Cal
Revised	12/01/2016	HH.2027	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2027Δ	Annual Risk Assessment (FDR)	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Annual Risk Assessment Tool	A tool utilized to stratify (high, medium, low) audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Audit & Oversight Committee (AOC)	CalOptima's Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is responsible for overseeing the delegated and internal activities of CalOptima.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	That committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox Keene Health Care Service Plan Act of 1975, Health & Safety Code, Sections 1340 *et seq.*
Downstream Entity	Any party that enters into a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
FDR ("FDR")	Means First Tier, Downstream or Related Entity, as separately defined herein.

Term	Definition
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to ~~deFraud~~defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Member	A beneficiary ~~who is~~ enrolled in a CalOptima program.
Regulatory Agencies	For the purposes of this policy Regulatory Agencies include Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG) and Office of Civil Rights (OCR).
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy:	HH.2027Δ
Title:	**Annual Risk Assessment (FDR)**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy describes the Annual Risk Assessment process conducted by CalOptima's Audit & Oversight Department to identify First Tier, Downstream, and Related Entities (FDRs) specific functional areas vulnerable to potential compliance risk. Such areas are documented in CalOptima's risk assessment, which will influence the development of CalOptima's FDR's audit and monitoring work plan.

II. POLICY

A. CalOptima maintains ultimate responsibility for adhering to and otherwise fully complying with its contract with the Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS). CalOptima is required to establish and implement an effective system of routine monitoring and identification of compliance risks.

B. At least annually, the Audit & Oversight Department is responsible for completing an Annual Risk Assessment to develop its FDR audit and monitoring work plan that ensures CalOptima's regulatory obligations are met. In assessing risk, the Audit & Oversight Department shall consider the following:

1. Statutory, regulatory, and contractual standards;
2. CalOptima's policies and procedures;
3. Business impact on Member care; and
4. Past compliance issues.

C. CalOptima shall, through contract or appropriate written arrangements, require the FDRs to conduct risk assessments, at least annually, and ongoing monitoring and audit of the Downstream Entities with which they contract to ensure compliance. CalOptima shall retain the right to conduct its own risk assessments and ongoing monitoring and audit of the Downstream Entities to ensure compliance.

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D. The Audit & Oversight Department shall stay current with all regulatory communication and guidance from the Regulatory Agencies.

E. The Audit & Oversight Department shall present Annual Risk Assessment results and the proposed FDR audit and monitoring work plan to both the Audit & Oversight Committee (AOC) and the Compliance Committee for review and approval by the end of the calendar year to be effective for the following year.

III. PROCEDURE

A. The Audit & Oversight Department shall undertake a discovery process of the FDRs, consisting of a document review to determine how regulatory, statutory, contractual, and CalOptima policy requirements are implemented; the operational effectiveness, and how the practices and the documentation support compliance. The analysis component of the Annual Risk Assessment is based on the evaluation of the FDRs' performance during the previous calendar year, including but not limited to ongoing monitoring and auditing results and focused reviews when applicable.

1. In the event that the FDR is a new delegate, the Audit & Oversight Department shall audit the FDR to collect baseline data in accordance with CalOptima Policy GG.1619: Delegation Oversight.

B. The Audit & Oversight Department shall consider the following information as it applies to FDRs, as part of the Annual Risk Assessment process:

1. A particular area identified by a Regulatory Agency as problematic through enforcement actions that may impact CalOptima, including but not limited to, National Committee for Quality Assurance (NCQA) status;

2. Regulatory audit findings;

3. CalOptima monitoring and audit findings;

4. Regulatory notices of non-compliance;

5. A completed questionnaire by the following CalOptima departments: (i) Regulatory Affairs and Compliance, (ii) Quality Improvement, (iii) Grievance and Appeals Resolution Services, (iv) Privacy, (v) Fraud, Waste & Abuse, and (vi) the business owner to provide knowledge of issues or trends being identified throughout CalOptima.

6. Accuracy of FDR encounter data submissions, coding, medical loss ratio (MLR) reported data, and other areas that may impact CalOptima payments (e.g., MLR, Hierarchical Condition Category (HCC) risk scores), if applicable;

7. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliance area; and

8. Whether the First Tier Entities (FTEs) are applying appropriate compliance program requirements to the Downstream Entities with which they contract, conducting risk assessments, at least annually, and performing ongoing monitoring and auditing of such Downstream Entities to ensure compliance.

C. The Audit & Oversight Department shall rely on data gathered using the Annual Risk Assessment,

and conduct baseline risk assessment audits evaluating file reviews, data collected from ongoing monitoring and auditing results and number of CAPs issued during the review period.

1. The Audit & Oversight Department shall compile the data and rank the risks based on the greatest impact on delegated operations and quality health care delivery to CalOptima Members.

D. The Audit & Oversight Department shall present the FDR risk assessment results and proposed audit and monitoring work plan to the AOC and subsequently to the Compliance Committee for approval.

E. The Audit & Oversight Department shall re-evaluate the work plan based on internal changes for approval (e.g., staffing and organizational structure changes, audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, Regulatory Agency audit results, etc.).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Contract for Health Care Services
E. CalOptima Compliance Plan
F. CalOptima Policy GG.1619: Delegation Oversight
G. Health Network Service Agreement
H. Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines
I. Prescription Drug Benefit Manual Chapter 9 - Compliance Program Guidelines
J. Title 42, Code of Federal Regulations (C.F.R.), §455.2
K. Welfare and Institutions Code §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	MA.9117	Annual Risk Assessment	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	09/01/2015	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2027	Annual Risk Assessment	Medi-Cal
Revised	12/01/2016	HH.2027	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2027Δ	Annual Risk Assessment (FDR)	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Annual Risk Assessment Tool	A tool utilized to stratify (high, medium, low) audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Audit & Oversight Committee (AOC)	CalOptima's Audit & Oversight Committee (AOC) is a subcommittee of the Compliance Committee and is responsible for overseeing the delegated and internal activities of CalOptima.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	That committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox Keene Health Care Service Plan Act of 1975, Health & Safety Code, Sections 1340 *et seq.*
Downstream Entity	Any party that enters into a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
FDR ("FDR")	Means First Tier, Downstream or Related Entity, as separately defined herein.

Term	Definition
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Member	A beneficiary enrolled in a CalOptima program.
Regulatory Agencies	For the purposes of this policy Regulatory Agencies include Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG) and Office of Civil Rights (OCR).
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.2028Δ
Title:	**Code of Conduct**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	~~*Michael Schrader*~~
Effective Date:	09/01/2015
Revision Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administration

I. PURPOSE

This policy describes the process CalOptima utilizes to review, approve, and communicate its expectation that all Employees, members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

II. POLICY

A. CalOptima requires that all members of the Governing Body, Employees, and FDRs to conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

B. Failure to comply with the Code of Conduct or the guidelines for behavior that the Code of Conduct represents may lead to disciplinary action, up to and including termination. Employees and FDRs are expected to inform CalOptima's Office of Compliance immediately in the event of any violation(s) to the Code of Conduct, in accordance with CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies.

C. Employees, members of the Governing Body, and FDRs shall provide attestations they have received, read, understood and will comply with the Code of Conduct upon appointment, hire, or the commencement of the contract and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.

III. PROCEDURE

A. Reviewing and Approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review of the current Code of Conduct, at least annually, or more frequently as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:

   a. Changes in state and federal laws, or regulations;

   b. Changes in health care program requirements; and

c. Other guidance, as applicable.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available on CalOptima's InfoNet, and vendor and provider websites.

B. Distributing and Monitoring for CalOptima Employees

1. All CalOptima Employees shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year, or annual, revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Department, who will communicate to all Employees that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

b. If there are revisions to the Code of Conduct that occur mid-year, the Human Resources Department shall compose and distribute an email to all Employees announcing an updated Code of Conduct is available on CalOptima's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

3. The Code of Conduct shall be communicated to all Employees through CalOptima's web-based learning management system or other means of distribution, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

C. Distributing and Monitoring for Members of the Governing Body

1. All members of CalOptima's Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, at least annually thereafter, and when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute the Code of Conduct via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training. The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.

b. If there are revisions to the Code of Conduct that occur mid-year, the Clerk of the Board shall compose and distribute a written memorandum to all members of the Governing Body announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

D. Distributing and Monitoring for FDRs

1. The Office of Compliance shall ensure the updated Code of Conduct is uploaded on to CalOptima vendor and Provider websites.

2. Upon contracting, the Office of Compliance distributes an FDR compliance attestation package composed of a cover letter containing a link to direct FDRs to CalOptima's policies and procedures, and Code of Conduct, as well as instructions on how to access CMS training modules on the topics for Fraud, Waste, and Abuse, General Compliance, and HIPAA. The packet also contains an FDR and Offshore attestation that are due within thirty (30) calendar days (for existing FDRs) or sixty (60) calendar days (new FDRs).

3. All CalOptima FDRs shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and Provider websites with notification of updates provided via email.

   a. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.

4. FDRs are required to disseminate copies of the CalOptima's Code of Conduct and policies and procedures to their employees, agents, and Downstream Entities, or distribute a comparable Compliance Plan and Code of Conduct. If the latter option, the FDR must submit a copy of its Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, to ensure they meet CMS requirements.

5. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs. Failure to submit the requested documents may result in issuance of a notice of non-compliance, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

6. The Office of Compliance shall communicate any update(s) to compliance documents, with instructions to access the CalOptima vendor and provider websites, to all FDRs.

IV. ATTACHMENT(S)

A. FDR Compliance Attestation

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~D.~~E. CalOptima PACE Program Agreement
~~E.~~F. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~F.~~G. CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies
~~G.~~H. CalOptima Policy HH.2023Δ: Compliance Training
~~H.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
I. Medicare Managed Care Manual, Chapter 21
J. Medicare Prescription Drug Benefit Manual, Chapter 9

K. Title 42, Code of Federal Regulations (C.F.R.), §455.2
L. Title 42, Code of Federal Regulations (C.F.R.), §422.503(b)(4)(vi)(A)
M. Title 42, Code of Federal Regulations (C.F.R.), §423.504(b)(4)(vi)(A)
N. Title 42, Code of Federal Regulations (C.F.R.), §438.608
O. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	MA.9120	Code of Conduct	OneCare
Revised	11/01/2014	MA.9120	Code of Conduct	OneCare
Effective	09/01/2015	HH.2028	Code of Conduct	Medi-Cal
Revised	09/01/2015	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	For purposes of this policy, a~~A~~ny and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

Policy:	HH.2028Δ
Title:	**Code of Conduct**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	
Effective Date:	09/01/2015
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Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administration

I. PURPOSE

This policy describes the process CalOptima utilizes to review, approve, and communicate its expectation that all Employees, members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

II. POLICY

A. CalOptima requires that all members of the Governing Body, Employees, and FDRs to conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

B. Failure to comply with the Code of Conduct or the guidelines for behavior that the Code of Conduct represents may lead to disciplinary action, up to and including termination. Employees and FDRs are expected to inform CalOptima's Office of Compliance immediately in the event of any violation(s) to the Code of Conduct, in accordance with CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies.

C. Employees, members of the Governing Body, and FDRs shall provide attestations they have received, read, understood and will comply with the Code of Conduct upon appointment, hire, or the commencement of the contract and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.

III. PROCEDURE

A. Reviewing and Approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review of the current Code of Conduct, at least annually, or more frequently as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:

   a. Changes in state and federal laws, or regulations;

   b. Changes in health care program requirements; and

c. Other guidance, as applicable.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available on CalOptima's InfoNet, and vendor and provider websites.

B. Distributing and Monitoring for CalOptima Employees

1. All CalOptima Employees shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year, or annual, revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Department, who will communicate to all Employees that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

b. If there are revisions to the Code of Conduct that occur mid-year, the Human Resources Department shall compose and distribute an email to all Employees announcing an updated Code of Conduct is available on CalOptima's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

3. The Code of Conduct shall be communicated to all Employees through CalOptima's web-based learning management system or other means of distribution, in accordance with CalOptima Policy HH.2023Δ: Compliance Training.

C. Distributing and Monitoring for Members of the Governing Body

1. All members of CalOptima's Governing Body shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, at least annually thereafter, and when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute the Code of Conduct via web-based training, in accordance with CalOptima Policy HH.2023Δ: Compliance Training. The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.

b. If there are revisions to the Code of Conduct that occur mid-year, the Clerk of the Board shall compose and distribute a written memorandum to all members of the Governing Body announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

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3. All CalOptima FDRs shall receive CalOptima's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima vendor and Provider websites with notification of updates provided via email.

    a. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima's Code of Conduct via the initial and annual FDR attestation.

4. FDRs are required to disseminate copies of the CalOptima's Code of Conduct and policies and procedures to their employees, agents, and Downstream Entities, or distribute a comparable Compliance Plan and Code of Conduct. If the latter option, the FDR must submit a copy of its Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, to ensure they meet CMS requirements.

5. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs. Failure to submit the requested documents may result in issuance of a notice of non-compliance, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

6. The Office of Compliance shall communicate any update(s) to compliance documents, with instructions to access the CalOptima vendor and provider websites, to all FDRs.

IV. ATTACHMENT(S)

A. FDR Compliance Attestation

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.2005Δ: Corrective Action Plan
G. CalOptima Policy HH.2019Δ: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Policies
H. CalOptima Policy HH.2023Δ: Compliance Training
I. Medicare Managed Care Manual, Chapter 21
J. Medicare Prescription Drug Benefit Manual, Chapter 9
K. Title 42, Code of Federal Regulations (C.F.R.), §455.2
L. Title 42, Code of Federal Regulations (C.F.R.), §422.503(b)(4)(vi)(A)

M. Title 42, Code of Federal Regulations (C.F.R.), §423.504(b)(4)(vi)(A)
N. Title 42, Code of Federal Regulations (C.F.R.), §438.608
O. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	MA.9120	Code of Conduct	OneCare
Revised	11/01/2014	MA.9120	Code of Conduct	OneCare
Effective	09/01/2015	HH.2028	Code of Conduct	Medi-Cal
Revised	09/01/2015	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9120	Code of Conduct	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2028Δ	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which Board Members, Employees, FDRs, and agents of CalOptima are expected to adhere.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director~~Annie Phillips~~, 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for ~~(~~existing FDRs~~)~~, or sixty (60) calendar days for ~~(~~new FDRs~~)~~ of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐PACE ☐Medi-Cal ☐OneCare ~~HMO SNP~~ ☐~~PACE~~

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and Fraud, Waste and Abuse (FWA) Training**. Provide effective ~~Fraud, Waste and Abuse~~FWA training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use:

(Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records ~~per CMS retention requirement~~ as evidence of completed training)

☐ An internal training program that ~~meets~~ utilizes content available in the CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records ~~per CMS retention requirement~~as evidence of completed training)

Note: If selecting an internal training program that ~~meets~~ aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers ~~: (i) based on their job function~~ within the first ninety (90) days of hire and at least annually thereafter as ~~a~~ condition of appointment, employment or contracting. ~~requirements change; (iii) when such persons work in an area previously found to be non-compliant with program requirements or implicated in past misconduct.~~

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III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

(Select which applies to your organization):

☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct (https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks.aspx)

☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the {Medi-Cal Suspended and Ineligible Provider List} (S & I Medi-Cal), {Health and Human Services} (HHS), {Office of Inspector General} (OIG) List of Excluded Individuals & Entities list, {System for Award Management} (SAM)/{General Services Administration} (GSA) Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (hereafter "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII. **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature	Date
Name (Print)	Organization
Email (Print)	

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

~~Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: CalOptima, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days (existing FDRs) or sixty (60) calendar days (new FDRs) of the notice accompanying this form.~~

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐OneCare Connect ☐PACE ☐OneCare ~~HMO~~ ☐ Medi-Cal
Please check one of the following: ☐ Our Organization does not offshore any protected health information. **Please skip to Part V below.** ☐ Our Organization does offshore protected health information. **Please complete Offshore Subcontractor Attestation (Part I through Part V) below.**	
~~Are any administrative or other functions conducted on behalf of your Organization by entities located offshore? This shall include employees of your firm, subcontractors and any 3rd party subcontractors.~~ ~~If **NO**, please **complete Part I** and **Part VI** of this form:~~ ~~If **YES**, please skip Part I, and **complete Parts II–VI** of this form~~	~~☐Yes ☐No~~

~~**Part I — Our Firm is Not Using Offshore Subcontractors and/or Employees**~~	
~~**Attestation**~~	~~**Response**~~
~~**Offshore subcontractors**: Our Organization does not currently use offshore subcontractors.~~	~~☐Yes ☐No~~
~~**Offshore employees**: Our Organization does not employ workers who are located offshore.~~	~~☐Yes ☐No~~
~~Name of organization:~~	
~~Name of authorized person:~~	
~~Title:~~	
~~Signature:~~	
~~Date:~~	

Part I~~I~~ — Offshore Subcontractor Information	
Attestation	**Response**
~~**Offshore employees:**~~ Our Organization ~~does employ~~uses an offshore subcontractor or offshore staff to perform functions that support our contract with ~~CaOptima~~CalOptima. ~~workers who are located offshore~~	☐Yes ☐No
Offshore Subcontractor name:	
Offshore Subcontractor country:	

Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II~~I~~ — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor~~: and/or employee:~~	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's~~/employee's~~ objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part ~~IV~~ III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that ~~Medi-Cal and~~ Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore ~~subcontractor/employee~~ subcontracting arrangement prohibits ~~subcontractor/employee~~ subcontractor's access to ~~Medi-Cal and~~ Medicare data not associated with CalOptima's contract with the offshore subcontractor~~/employee~~.	☐Yes ☐No*
C. ~~Describe alternatives considered to avoid providing PHI, and why each alternative was rejected.~~ Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore ~~subcontractor/employee~~ subcontracting arrangement includes all required ~~DHCS (Department of Health Care Services) and/or CMS (Centers for Medicare & Medicaid Services)~~ Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)~~as stipulated within your contract with CalOptima~~	☐Yes ☐No*

~~*Explanation required for "no" response to Part IV items A to D above:~~

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. ~~Yo~~Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by ~~y~~our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. ~~Your~~ Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐Yes ☐No*
~~D. Our organization agrees to notify CalOptima at least 60 days in advance of our intent to use new offshore subcontractor(s) or before employing new offshore staff for a function CalOptima has asked us to perform.~~	~~☐Yes ☐No*~~

***~~Please provide explanation~~Explanation required for all "no" responses ~~to~~to Part III ~~if "no" select for Part V items A to D C and~~and Part IV ~~items A to C~~above:**

Part V~~I~~ — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx~~https://www.caloptima.org/en/Vendors/FDRCompllianceInformation.aspx~~

FDR COMPLIANCE ATTESTATION

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Which CalOptima program(s) does this form pertain to? Select all that apply:	☐ OneCare Connect ☐ PACE ☐ Medi-Cal ☐ OneCare

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and Fraud, Waste and Abuse (FWA) Training**. Provide effective FWA training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use:

(Select all that apply):

☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records as evidence of completed training)

☐ An internal training program that utilizes content available in the CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records as evidence of completed training)

Note: If selecting an internal training program that aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting.

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III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR §422.503(b)(4)(vi)(A) and 42 CFR §423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization.

(Select which applies to your organization):

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☐ Organization has distributed a comparable Compliance Plan and Code of Conduct
Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review to ensure they meet CMS's requirements.

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the Medi-Cal Suspended and Ineligible Provider List (S & I Medi-Cal), Health and Human Services (HHS), Office of Inspector General (OIG) List of Excluded Individuals & Entities list, System for Award Management (SAM)/General Services Administration (GSA) Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (hereafter "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non-compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII. **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non-compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature	Date
Name (Print)	Organization
Email (Print)	

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☐OneCare Connect ☐PACE ☐OneCare ☐ Medi-Cal

Please check one of the following:

☐ Our Organization does not offshore any protected health information.
Please skip to Part V below.

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below.

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima.	☐Yes ☐No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor:	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐Yes ☐No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language. (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐Yes ☐No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐Yes ☐No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person:	Title:
Email:	Phone #:
Signature:	Date:

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

24. Consider Approval of Modifications to CalOptima Policy FF.1007: Health Network Reinsurance Coverage and FF.4000 Whole-Child Model – Financial Reimbursement for Capitated Health Networks

Contact

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

Recommended Actions

Approve modifications to the following policies pursuant to CalOptima's annual policy review process:

1. CalOptima Policy FF.1007: Health Network Reinsurance Coverage; and
2. CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks

Background

CalOptima establishes new and modifies existing policies and procedures to implement federal and state laws, regulations, contracts, and business practices. In addition, CalOptima staff performs an annual policy review to update internal policies and procedures to ensure compliance with applicable requirements. Effective January 1, 2021, the Department of Health Care Service (DHCS) was planning to transition the pharmacy benefit for Medi-Cal beneficiaries from managed care plans to a fee-for-service program administered at the state level (i.e., Medi-Cal Rx). On November 16, 2020, DHCS announced the transition date has been postponed until April 1, 2021.

Discussion

Staff recommends revisions to the following CalOptima policies in consideration of this change:

- CalOptima Policy FF.1007: Health Network Reinsurance Coverage. This policy sets forth CalOptima's reinsurance coverage for Health Networks, excluding any Health Maintenance Organizations (HMOs) that are financially at-risk for catastrophic claims. CalOptima staff has proposed revisions to this policy pursuant to the CalOptima annual review process to ensure alignment with current operational systems and regulatory requirements.

- CalOptima Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks. This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to health networks, including HMOs, Physician Hospital Consortia (PHC), and Shared Risk Groups (SRG). CalOptima revised this policy pursuant to the CalOptima annual review process to ensure compliance with DHCS All Plan Letter (APL) 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayment to Providers, and regulatory requirements of Medi-Cal Rx carve-out. Proposed revisions to this policy include adding an email address to submit an appeal for WCM reimbursement, and clarifying that effective with the transition to Medi-Cal Rx, pharmacy expenses provided to California Children's Services (CCS) eligible Kaiser members will be excluded from the policy.

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Fiscal Impact
The recommended action to approve revisions to existing CalOptima financial policies and procedures is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation
The recommended action will enhance the efficiency of CalOptima's operations and governance and ensure compliance with applicable regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Policy FF.1007: Health Network Reinsurance Coverage (redlined and clean)
2. CalOptima Policy FF. 4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks (redlined and clean)

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

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Policy:	FF.1007
Title:	**Health Network Reinsurance Coverage**
Department:	Finance
Section:	Not Applicable
CEO Approval:	
Effective Date:	07/01/2010
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy sets forth CalOptima's reinsurance coverage for Health Networks, excluding any Health Maintenance Organizations (HMOs) that are financially at-risk for catastrophic claims.

II. POLICY

A. CalOptima shall provide reinsurance coverage to its eligible Health Networks, in accordance with this policy.

B. Effective on the Department of Health Care Services (DHCS) approved Whole Child Model (WCM) program implementation date, no sooner than July 1, 2019, claims for services to Members eligible for California Children's Services (CCS) Program shall be excluded from this Policy.

C. The coverage period for this policy is each CalOptima fiscal year beginning 12:01 a.m. Pacific Time (PT) July 1 through 12:00 a.m. PT June 30.

D. Reinsurance coverage applies to claims incurred within the coverage period and paid by the eligible Health Network no later than six (6) months after the end of the coverage period.

E. An eligible Health Network shall submit reinsurance claims to CalOptima no later than December 31 following the end of the previous fiscal year to be eligible for reimbursement:

1. An eligible HMO may submit reinsurance claims for covered hospital and covered physician expenses;

2. A Primary Physician Group may submit reinsurance claims for covered physician expenses;

3. A Primary Hospital may submit reinsurance claims for covered hospital expenses; and

4. A Shared Risk Group (SRG) may submit reinsurance claims for covered physician expenses.

F. CalOptima shall identify reinsurance claims and payment of benefits for hospital expenses for Members assigned to an SRG, in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

G. Covered expenses include those Covered Services that are delegated to an eligible Health Network, and Shared Risk services, as defined in the Division of Financial Responsibility (DOFR) between

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CalOptima and the eligible Health Network, except those services listed in Section II.H of this Policy.

1. Covered hospital expenses are either:

   a. Those Covered Services listed in the DOFR between CalOptima and a Primary Hospital in the Contract for Health Care Services – Hospital; or

   b. Those Covered Services listed in the DOFR between CalOptima and an eligible HMO in the Contract for Health Care Services; or

   c. Shared Risk services listed in the DOFR between CalOptima and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

2. Covered physician expenses are either:

   a. Those Covered Services listed in the DOFR between CalOptima and a Primary Physician Group in the Contract for Health Care Services – Physician; or

   b. Those Covered Services listed in the DOFR between CalOptima and an eligible HMO in the Contract for Health Care Services; or

   c. Shared Risk services listed in the DOFR between CalOptima and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

H. Covered expenses exclude Capitation Payments, and any other non-Covered Service, exclusion, or Covered Service that is not a Shared Risk service that is the financial responsibility of CalOptima. This includes covered Transplant services, and Health Network Transplant claims denied for payment due to administrative reasons (e.g., timeliness).

I. Covered expenses are subject to the following limitations:

1. Hospital services:

   a. For contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the Contracted CalOptima Direct (COD) Hospital Rate, averaged over the entire length of stay or stays.

   b. For non-contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the non-contracted COD hospital rate, averaged over the entire length of stay or stays.

      i. For non-contracted emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the amount specified for non-contracted emergency hospital inpatient services in CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

      ii. For non-contracted post-stabilization inpatient services, up to the amount specified for non-contracted post-stabilization inpatient services, in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group; and Policy FF.2001: Claims

Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

iii. For non-contracted out-of-state emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the All Patient Refined Diagnosis-Related Groups (APR-DRG) paid by Medi-Cal Fee-For-Service for out-of-State hospital inpatient services.

c. All calculations shall be made prior to the application of Deductible or coinsurance. CalOptima shall accept a completed UB-04 form as proof of payment for capitated hospital services. A hospital shall not include any loss for home health services or outpatient services, or for days of confinement in an extended care facility or rehabilitation facility.

2. Physician services:

a. The lesser of the amount paid for covered physician expenses or:

i. One hundred twenty-nine percent (129%) of the current CalOptima Medi-Cal Fee Schedule in effect on the date of service; or

ii. Fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by the Department of Health Care Services (DHCS).

b. The above calculation shall be made prior to the application of Deductible or coinsurance. CalOptima shall accept a completed CMS-1500 form as proof of payment for capitated physician services.

3. Hemodialysis services: Limited to one thousand dollars ($1,000) per calendar day.

4. Chemotherapy drugs and related services: Limited to one thousand dollars ($1,000) per calendar day, for services billed as a medical claim.

5. In the absence of other limitations, CalOptima shall calculate covered expenses by summing all hospital or physician covered expenses per Member~~s~~ per coverage period, as applicable by Section II.E of this Policy, subject to the annual Deductible.

J. Annual Deductibles are as follows:

1. Hospital Deductible:

a. One hundred fifty thousand dollars ($150,000) of covered hospital expenses per Member~~s~~ during the coverage period.

b. Subject to the terms of this policy, CalOptima shall reimburse eighty percent (80%) of the expenses after a Deductible of one hundred fifty thousand dollars ($150,000) is applied.

2. Physician Deductible:

a. Seventeen thousand dollars ($17,000) of covered physician expenses per Member~~s~~ during the coverage period.

b. Subject to the terms of this policy, CalOptima shall reimburse eighty percent (80%) of the expenses after a Deductible of seventeen thousand dollars ($17,000) is applied.

K. The maximum reinsurance amount payable under this policy for covered expenses for a Member~~s~~ is calculated on the basis of one million dollars ($1,000,000) of coverage per Member~~s~~ per coverage period, minus the applicable annual Deductible and coinsurance, and subject to any limitations noted in this Policy.

III. PROCEDURE

A. Process to submit reinsurance claims for covered expenses, except hospital expenses for a Member~~s~~ assigned to a Shared Risk Group:

1. An eligible Health Network shall submit reinsurance claims on a quarterly basis, no later than the twentieth (20th) calendar day of the month following the end of a quarter.

2. An eligible Health Network shall submit reinsurance claims using CalOptima's proprietary format and file naming convention, as described in the Reinsurance Field Names and Values for Electronic File Transmission. An eligible Health Network may submit the reinsurance claims file by transmitting an encrypted electronic mail to reinsurance@caloptima.org, submitting electronically to CalOptima's secure FTP site, or by mailing an encrypted Universal Serial Bus (USB) flash drive, compact disk (CD) or Digital Versatile Disc (DVD) to:

   Attention: Coding Initiatives Department—Reinsurance Claims
   CalOptima
   505 City Parkway West
   Orange, CA 92868

3. Reinsurance claims shall include:

   a. Claims paid by an eligible Health Network during that quarter only; or

   b. Claims detail for qualified Members who reached the annual Deductible.

4. Upon request, an eligible Health Network shall provide detailed support, within ten (10) business days, for any individual claim for which billed charges are greater than, or equal to, ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information, as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

5. CalOptima shall notify an eligible Health Network of file acceptance or rejection within ten (10) business days after receipt.

   a. CalOptima may reject a file for any missing information or incorrect data.

   b. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days from receipt of notification from CalOptima.

6. CalOptima shall provide an eligible Health Network with detailed reports of claims processed within forty-five (45) business days after the quarter end submission date.

7. An eligible Health Network may appeal claim denials and underpayments within sixty (60) business days after the date of CalOptima's RAD.

   a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at reinsurance@caloptima.org or by U.S. mail to:

      Attention: Coding Initiatives Department—Reinsurance Claims
      CalOptima
      505 City Parkway West
      Orange, CA 92868

   b. The eligible Health Network shall submit the appeals claims submission file in the same format as the initial claims submission, in accordance with the Reinsurance Field Names and Values for Electronic File Transmission.

   c. An appeals claims submission file shall only include specific claims to be reconsidered.

   d. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

   e. CalOptima shall notify the eligible Health Network of file acceptance or rejection within ten (10) business days after receipt of the appeal file.

      i. CalOptima may reject a file for any missing information or incorrect data.

      ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

   f. CalOptima shall process an appeal and provide an eligible Health Network with detailed reports within forty-five (45) business days after receipt of the appeal.

B. If a loss exceeds, or is expected to exceed, the annual Deductible by ten thousand dollars ($10,000), CalOptima may appoint CalOptima staff to represent CalOptima's interest in the ongoing administration of the loss. An eligible Health Network shall cooperate with CalOptima staff in the ongoing administration of the loss.

C. In the event of termination of the Contract for Health Care Services between an eligible Health Network and CalOptima, the coverage period shall end three (3) months after the termination date. A terminated eligible Health Network shall submit reinsurance claims no later than six (6) months after the termination date in order to receive reimbursement.

D. An eligible Health Network shall make books and records available to CalOptima for inspection and audit at any time during normal business hours in accordance with the Contract for Health Care Services.

IV. ATTACHMENT(S)

A. Reinsurance Field Names and Values for Electronic File Transmission

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group
~~C. CalOptima Policy FF.1007_2017-2018: Health Network Reinsurance Coverage~~
~~D.~~C. CalOptima Policy FF.1010: Shared Risk Pool
~~E.~~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
~~F.~~E. CalOptima Policy FF.3001: Financial Reporting
~~G.~~F. Contract for Health Care Services
~~H.~~G. Title 42, United States Code, Section 1396u-2(b)(2)(D)
~~I.~~H. This policy supersedes:
1. CalOptima Financial Bulletin #7: Policy FF.1101: Excess Risk Liability Program
2. CalOptima Financial Bulletin #32: Revisions to FF.1200: Health Network Reinsurance Coverage
3. CalOptima Financial Bulletin #34: Revisions to FF.1200: Health Network Reinsurance Coverage
4. CalOptima Financial Bulletin #35: Health Network Reinsurance Program for SPD over Age 45

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
12/10/2010	Department of Health Care Services (DHCS)
08/06/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
09/11/2007	Regular Meeting of the CalOptima Board of Directors
09/04/2008	Regular Meeting of the CalOptima Board of Directors
09/17/2009	Special Meeting of the CalOptima Board of Directors' Finance and Audit Committee
10/01/2009	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2010	FF.1007_2009-2010	Health Network Reinsurance Coverage	Medi-Cal
Revised	07/01/2011	FF.1007_2010-2011	Health Network Reinsurance Coverage	Medi-Cal
Revised	03/01/2012	FF.1007_2011-2012	Health Network Reinsurance Coverage	Medi-Cal
Revised	10/01/2012	FF.1007_2012-2013	Health Network Reinsurance Coverage	Medi-Cal
Revised	12/01/2013	FF.1007_2013-2014	Health Network Reinsurance Coverage	Medi-Cal
Revised	04/01/2015	FF.1007_2014-2015	Health Network Reinsurance Coverage	Medi-Cal
Revised	02/01/2016	FF.1007_2015-2016	Health Network Reinsurance Coverage	Medi-Cal
Revised	07/01/2016	FF.1007_2016-2017	Health Network Reinsurance Coverage	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2017	FF.1007_2017-2018	Health Network Reinsurance Coverage	Medi-Cal
Revised	10/04/2018	FF.1007	Health Network Reinsurance Coverage	Medi-Cal
Revised	10/01/2019	FF.1007	Health Network Reinsurance Coverage	Medi-Cal
Revised		FF.1007	Health Network Reinsurance Coverage	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons 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.
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.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
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), 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), 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.~~

Term	Definition
Deductible	For purposes of this policy, the amount set forth in Section III.I of this policy, which the eligible Health Network must pay in eligible expenses on behalf of a Member during the coverage period, before CalOptima is responsible for reimbursing the eligible Health Network eighty percent (80%) of eligible expenses for that Member.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
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.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Remittance Advice Detail (RAD)	A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.
Shared Risk Group	A Health Network that 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.
Transplant	A Non-Experimental Procedure for human tissue or organ Transplant.
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Policy:	FF.1007
Title:	**Health Network Reinsurance Coverage**
Department:	Finance
Section:	Not Applicable
CEO Approval:	
Effective Date:	07/01/2010
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy sets forth CalOptima's reinsurance coverage for Health Networks, excluding any Health Maintenance Organizations (HMOs) that are financially at-risk for catastrophic claims.

II. POLICY

A. CalOptima shall provide reinsurance coverage to its eligible Health Networks, in accordance with this policy.

B. Effective on the Department of Health Care Services (DHCS) approved Whole Child Model (WCM) program implementation date, no sooner than July 1, 2019, claims for services to Members eligible for California Children's Services (CCS) Program shall be excluded from this Policy.

C. The coverage period for this policy is each CalOptima fiscal year beginning 12:01 a.m. Pacific Time (PT) July 1 through 12:00 a.m. PT June 30.

D. Reinsurance coverage applies to claims incurred within the coverage period and paid by the eligible Health Network no later than six (6) months after the end of the coverage period.

E. An eligible Health Network shall submit reinsurance claims to CalOptima no later than December 31 following the end of the previous fiscal year to be eligible for reimbursement:

1. An eligible HMO may submit reinsurance claims for covered hospital and covered physician expenses;

2. A Primary Physician Group may submit reinsurance claims for covered physician expenses;

3. A Primary Hospital may submit reinsurance claims for covered hospital expenses; and

4. A Shared Risk Group (SRG) may submit reinsurance claims for covered physician expenses.

F. CalOptima shall identify reinsurance claims and payment of benefits for hospital expenses for Members assigned to an SRG, in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

G. Covered expenses include those Covered Services that are delegated to an eligible Health Network, and Shared Risk services, as defined in the Division of Financial Responsibility (DOFR) between

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CalOptima and the eligible Health Network, except those services listed in Section II.H of this Policy.

1. Covered hospital expenses are either:

   a. Those Covered Services listed in the DOFR between CalOptima and a Primary Hospital in the Contract for Health Care Services – Hospital; or

   b. Those Covered Services listed in the DOFR between CalOptima and an eligible HMO in the Contract for Health Care Services; or

   c. Shared Risk services listed in the DOFR between CalOptima and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

2. Covered physician expenses are either:

   a. Those Covered Services listed in the DOFR between CalOptima and a Primary Physician Group in the Contract for Health Care Services – Physician; or

   b. Those Covered Services listed in the DOFR between CalOptima and an eligible HMO in the Contract for Health Care Services; or

   c. Shared Risk services listed in the DOFR between CalOptima and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

H. Covered expenses exclude Capitation Payments, and any other non-Covered Service, exclusion, or Covered Service that is not a Shared Risk service that is the financial responsibility of CalOptima. This includes covered Transplant services, and Health Network Transplant claims denied for payment due to administrative reasons (e.g., timeliness).

I. Covered expenses are subject to the following limitations:

1. Hospital services:

   a. For contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the Contracted CalOptima Direct (COD) Hospital Rate, averaged over the entire length of stay or stays.

   b. For non-contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the non-contracted COD hospital rate, averaged over the entire length of stay or stays.

      i. For non-contracted emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the amount specified for non-contracted emergency hospital inpatient services in CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

      ii. For non-contracted post-stabilization inpatient services, up to the amount specified for non-contracted post-stabilization inpatient services, in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group; and Policy FF.2001: Claims

Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

iii. For non-contracted out-of-state emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the All Patient Refined Diagnosis-Related Groups (APR-DRG) paid by Medi-Cal Fee-For-Service for out-of-State hospital inpatient services.

c. All calculations shall be made prior to the application of Deductible or coinsurance. CalOptima shall accept a completed UB-04 form as proof of payment for capitated hospital services. A hospital shall not include any loss for home health services or outpatient services, or for days of confinement in an extended care facility or rehabilitation facility.

2. Physician services:

a. The lesser of the amount paid for covered physician expenses or:

i. One hundred twenty-nine percent (129%) of the current CalOptima Medi-Cal Fee Schedule in effect on the date of service; or

ii. Fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by the Department of Health Care Services (DHCS).

b. The above calculation shall be made prior to the application of Deductible or coinsurance. CalOptima shall accept a completed CMS-1500 form as proof of payment for capitated physician services.

3. Hemodialysis services: Limited to one thousand dollars ($1,000) per calendar day.

4. Chemotherapy drugs and related services: Limited to one thousand dollars ($1,000) per calendar day, for services billed as a medical claim.

5. In the absence of other limitations, CalOptima shall calculate covered expenses by summing all hospital or physician covered expenses per Member per coverage period, as applicable by Section II.E of this Policy, subject to the annual Deductible.

J. Annual Deductibles are as follows:

1. Hospital Deductible:

a. One hundred fifty thousand dollars ($150,000) of covered hospital expenses per Member during the coverage period.

b. Subject to the terms of this policy, CalOptima shall reimburse eighty percent (80%) of the expenses after a Deductible of one hundred fifty thousand dollars ($150,000) is applied.

2. Physician Deductible:

a. Seventeen thousand dollars ($17,000) of covered physician expenses per Member during the coverage period.

b. Subject to the terms of this policy, CalOptima shall reimburse eighty percent (80%) of the expenses after a Deductible of seventeen thousand dollars ($17,000) is applied.

K. The maximum reinsurance amount payable under this policy for covered expenses for a Member is calculated on the basis of one million dollars ($1,000,000) of coverage per Member per coverage period, minus the applicable annual Deductible and coinsurance, and subject to any limitations noted in this Policy.

III. PROCEDURE

A. Process to submit reinsurance claims for covered expenses, except hospital expenses for a Member assigned to a Shared Risk Group:

1. An eligible Health Network shall submit reinsurance claims on a quarterly basis, no later than the twentieth (20th) calendar day of the month following the end of a quarter.

2. An eligible Health Network shall submit reinsurance claims using CalOptima's proprietary format and file naming convention, as described in the Reinsurance Field Names and Values for Electronic File Transmission. An eligible Health Network may submit the reinsurance claims file by transmitting an encrypted electronic mail to reinsurance@caloptima.org, submitting electronically to CalOptima's secure FTP site, or by mailing an encrypted Universal Serial Bus (USB) flash drive, compact disk (CD) or Digital Versatile Disc (DVD) to:

   Attention: Coding Initiatives Department—Reinsurance Claims
   CalOptima
   505 City Parkway West
   Orange, CA 92868

3. Reinsurance claims shall include:

   a. Claims paid by an eligible Health Network during that quarter only; or

   b. Claims detail for qualified Members who reached the annual Deductible.

4. Upon request, an eligible Health Network shall provide detailed support, within ten (10) business days, for any individual claim for which billed charges are greater than, or equal to, ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information, as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

5. CalOptima shall notify an eligible Health Network of file acceptance or rejection within ten (10) business days after receipt.

   a. CalOptima may reject a file for any missing information or incorrect data.

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6. CalOptima shall provide an eligible Health Network with detailed reports of claims processed within forty-five (45) business days after the quarter end submission date.

7. An eligible Health Network may appeal claim denials and underpayments within sixty (60) business days after the date of CalOptima's RAD.

   a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at reinsurance@caloptima.org or by U.S. mail to:

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   b. The eligible Health Network shall submit the appeals claims submission file in the same format as the initial claims submission, in accordance with the Reinsurance Field Names and Values for Electronic File Transmission.

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   f. CalOptima shall process an appeal and provide an eligible Health Network with detailed reports within forty-five (45) business days after receipt of the appeal.

B. If a loss exceeds, or is expected to exceed, the annual Deductible by ten thousand dollars ($10,000), CalOptima may appoint CalOptima staff to represent CalOptima's interest in the ongoing administration of the loss. An eligible Health Network shall cooperate with CalOptima staff in the ongoing administration of the loss.

C. In the event of termination of the Contract for Health Care Services between an eligible Health Network and CalOptima, the coverage period shall end three (3) months after the termination date. A terminated eligible Health Network shall submit reinsurance claims no later than six (6) months after the termination date in order to receive reimbursement.

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IV. ATTACHMENT(S)

A. Reinsurance Field Names and Values for Electronic File Transmission

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
12/10/2010	Department of Health Care Services (DHCS)
08/06/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

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VIII. REVISION HISTORY

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Revised	07/01/2011	FF.1007_2010-2011	Health Network Reinsurance Coverage	Medi-Cal
Revised	03/01/2012	FF.1007_2011-2012	Health Network Reinsurance Coverage	Medi-Cal
Revised	10/01/2012	FF.1007_2012-2013	Health Network Reinsurance Coverage	Medi-Cal
Revised	12/01/2013	FF.1007_2013-2014	Health Network Reinsurance Coverage	Medi-Cal
Revised	04/01/2015	FF.1007_2014-2015	Health Network Reinsurance Coverage	Medi-Cal
Revised	02/01/2016	FF.1007_2015-2016	Health Network Reinsurance Coverage	Medi-Cal
Revised	07/01/2016	FF.1007_2016-2017	Health Network Reinsurance Coverage	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
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Revised		FF.1007	Health Network Reinsurance Coverage	Medi-Cal

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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.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
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), 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), 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.
Deductible	For purposes of this policy, the amount set forth in Section III.I of this policy, which the eligible Health Network must pay in eligible expenses on behalf of a Member during the coverage period, before CalOptima is responsible for reimbursing the eligible Health Network eighty percent (80%) of eligible expenses for that Member.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Term	Definition
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
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.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Remittance Advice Detail (RAD)	A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.
Shared Risk Group	A Health Network that 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.
Transplant	A Non-Experimental Procedure for human tissue or organ Transplant.
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

1

Reinsurance Field Names and Values for Electronic File Transmission					
Accepted Format: Access or Excel (Excel is preferred)					
Field Names	**Descriptions**	**Data Type**	**Field Length**	**Example Entry**	**Notes**
HNNumber	Health Network Numbers	Alpha Numeric	6	PHC058	HMO, SRG, or PHC; and 3 digits for health network. For example, PHC058
MemberID	CIN Number	Text	9	99999999D	
MemberName	Member Names	Text	Up to 50	Jane Doe	
DOB	Date of Birth	Date (mm/dd/yy)		05/01/62	
ClaimNo	Claim Number	Alpha Numeric	Upto 25	2005042899903140	
ClaimType	Claim Type	Text	Upto 25	Professional	Professional
				IP Hospital	Inpatient
				OP Hospital	Outpatient
ProviderID	Provider License/NPI	Alpha Numeric	12	XXXX01250	
ProviderName	Provider Name	Text	Up to 50	XXXXX, MD	
TIN	Tax Idenfification Number	Text	Upto 15	123456789	
FrDOS	From Date of service	Date (mm/dd/yy)		1/1/2020	Specific Date of service must be entered not DOS range to avoid any denials due to duplication of service.
ToDOS	To Date of Service	Date (mm/dd/yy)		1/31/2020	Specific Date of service must be entered not DOS range to avoid any denials due to duplication of service.
POS	Place of Service	Text	2	21	
Procedurecode	Procedure codes	Alpha Numeric	5	80053	
Modifier	Modifier	Alpha Numeric	2	26	26
RevenueCode	Revenue codes	Alpha Numeric	3	270	270
Dx	Diagnosis Codes	Alpha Numeric	3 to 13	70715	No period or dot in between diagnosis code
Units_Days	Units or Days	Numeric	Numeric	10	For Anesthesia procedure, enter converted total number of units (Anesthesia Units plus modifier units plus time units).
BilledAmt	Billed Amount	Currency	Currency	$0.00	
PaidAmt	Paid Amount	Currency	Currency	$0.00	
CheckNumber	Check Number	Alpha Numeric	Upto 10	1234567899	
CheckDate	Check Date	Date (mm/dd/yy)		mm/dd/yy	
CAP_Ind	Capitated Indicator	Text	1	Y or N	
CAPAmt	Capitated Amount	Currency		$0.00	
Quarter	Quarter	Text	6	Q12020	This is the quarter when the file is submitted.
FileName	Naming convention	Text	8	58PRQ120	Must submit separate file per claim type (Professional and Hospital claims) (See "File Naming Convention" below).
Adjustment_ind	Adjustment indicator	Text	1	Y or N	New field added to identify adjustment to original claim to avoid any denials due to duplicate service.
Appeal Reason	Appeal Reason	Text	Up to 250		Only applies to appeal and must include reason for the appeal.

File Naming Convention				**Value**	
13 Character Length					
First 2 character is designated for HN number				58	
Third character is the file type				P = professional, H = Hospital	
Fourth character is the program/incentive				R = Reinsurance	
Fifth to Eight character is designated as the Quarter file submission				Q120	
Last 5 characters are designated for the Policy Year as in "Fiscal Year"				_2020	
For example: Amvi professional file for Fiscal Year 2012				58PRQ120_2020	
Note: please rename file with prefix "1_FINRPT_" if submitting into FTP site				1_FINPRT_58PRQ120_2020	

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Policy:	FF.4000
Title:	**Whole-Child Model – Financial Reimbursement for Capitated Health Networks**
Department:	CalOptima Administrative
Section:	Finance - Accounting
CEO Approval:	
Effective Date:	07/01/2019
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to Health Networks, including Health Maintenance Organizations (HMO), Physician Hospital ~~Consortiums~~ Consortia (PHC), and Shared Risk Groups (SRG).

II. POLICY

A. CalOptima shall pay the Health Network in accordance with the Health Network's Contract for Health Care Services, the CalOptima Board of Directors (BOD)-approved payment methodology, and the terms and conditions of this Policy.

B. CalOptima's WCM reimbursement methodology for Health Networks is based on the number of California Children's Services (CCS) Program-eligible Members, as identified by the local CCS Program, ~~and~~ enrolled in Health Networks during the applicable period.

C. If the local CCS Program identifies that an individual was not eligible for the CCS Program and retroactively terminates CCS eligibility, CalOptima shall recover payments made to the Health Network for such individual.

D. CalOptima Direct-Administrative (COD-A) is financially responsible for all Covered Services provided during a month in which a CCS-eligible Member has retroactive eligibility.

E. In accordance with CalOptima Policy FF.1007: Health Network Reinsurance Coverage, CalOptima shall exclude Members from the provision of reinsurance as of the effective date of the Member being CCS-eligible.

F. The Measurement Period for WCM payments is established by fiscal year (FY), July 1 to June 30. In accordance with Section II.J.3 of this Policy, CalOptima shall keep each Measurement Period (FY1) open for thirty (30) months after the end of each Measurement Period before the risk corridor reconciliation is considered finalized (e.g., Measurement Period FY 2019-20 (July 1, 2019 – June 30, 2020) will be finalized based on claims paid through December 31, 2022).

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G. CalOptima reimburses Health Networks, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), for services rendered to enrolled CCS-eligible Members based on a methodology that includes the following components described in this Policy:

1. Initial Capitation Payments;

2. Interim catastrophic payment; and

3. Retrospective risk corridor settlements.

H. CalOptima shall reimburse Kaiser for services rendered to enrolled CCS-eligible Members based on a methodology described in Section III.G. of this Policy.

I. CalOptima may adjust Health Network initial Capitation Payment rates subject to Department of Health Care Services (DHCS) funding updates for the Measurement Period.

J. The WCM payment timelines are:

1. Initial Capitation Payment: CalOptima shall pay monthly on or before the fifteenth (15th) calendar day of the month.

2. Interim catastrophic payment: CalOptima shall pay quarterly based on the refreshed data for each Measurement Period as follows:

CCS Eligible and Claims Incurred for Dates of Service	Claims Payment Period	Interim Catastrophic Calculation (Payment/ Recoupment) Date
July 1 – September 30, FY1	FY1 paid through September 30, FY1	No later than November 30, FY1
July 1 – December 31, FY1	FY1 paid through December 31, FY1	No later than February 28, FY1
July 1 – March 31, FY1	FY1 paid through March 31, FY1	No later than May 31, FY1
July 1 – June 30, FY1	FY1 paid through June 30, FY1	No later than August 31, FY2
July 1 – June 30, FY1	FY1 paid through September 30, FY2	No later than November 30, FY2

3. Retrospective risk corridor settlement: CalOptima shall pay annually based on the refreshed data for each Measurement Period as follows:

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 6 months: FY1 paid through December 31, FY2	No later than May 15, FY2
July 1 – June 30, FY1	Measurement Period plus 18 months: FY1 paid through December 31, FY3	No later than May 15, FY3

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 30 months (final): FY1 paid through December 31, FY4	No later than May 15, FY4

III. PROCEDURE

A. Initial Capitation Payment

1. CalOptima shall provide monthly Capitation Payments for CCS-eligible Members enrolled in the Health Networks at Capitation Rates per Member per month (PMPM) developed by CalOptima, approved by the BOD and set forth in the Health Network's Contract for Health Care Services.

2. CalOptima shall process the initial Capitation Payment in accordance with CalOptima Policy FF.1001: Capitation Payments. CalOptima shall issue one (1) payment that includes the initial Capitation Payment for CCS-eligible Members combined with the Capitation Payment for non-CCS eligible Members.

B. Interim Catastrophic Payment

1. Health Networks shall submit paid claims through the existing monthly External Decision Data submission for covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members monthly, by the fifteenth (15th) calendar day after the month ends for all Open Measurement Periods. Health Networks shall submit claims using CalOptima's proprietary format and file naming convention.

   a. An HMO, with the exception of Kaiser, shall submit claims for covered hospital and covered physician expenses;

   b. The Primary Physician Group of a PHC shall submit claims for covered physician expenses;

   c. The Primary Hospital of a PHC shall submit claims for covered hospital expenses; and

   d. An SRG shall submit claims for covered physician expenses.

2. CalOptima shall validate and reprice the submitted claims based on the CalOptima contracted and non-contracted rates following the lesser of the amount paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five (5)-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by DHCS. These allowable claims, as determined by CalOptima, shall represent the repriced WCM medical expenses used in the reconciliation process for the interim catastrophic reimbursement. Claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. Upon request, an eligible Health Network shall provide, within five (5) business days, detailed support for any individual claim for which billed charges are greater than or equal to ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits

(EOB), Remittance Advice Detail (RAD), and other information as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

4. CalOptima shall notify an eligible Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for missing information or incorrect data. If CalOptima rejects a file, an eligible Health Network shall resubmit a corrected file no later than September 30, FY2 of the claims payment period pursuant to Section II.J.2 of this Policy. Any timely resubmission after the fifteenth (15th) of the month will be included in the subsequent month's process. A paid claims file initially submitted or a corrected file resubmitted by an eligible Health Network after the September 30, FY2 deadline will be processed in accordance with the requirements of the annual retrospective risk corridor reconciliation as set forth in Sections II.J.3 and III.C of this Policy.

5. For a complete claims paid file accepted by CalOptima, CalOptima shall notify an eligible Health Network of the results as follows:

   a. If CalOptima receives the file by the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of that month.

   b. If CalOptima receives the file after the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of the subsequent month.

6. An eligible Health Network may appeal claim denials and payments within sixty (60) business days after the date of CalOptima's quarterly interim catastrophic payment remittance advice.

   a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at:

      WCMReimb@caloptima.org

      Or by U.S. mail to:

      Attn: Coding Initiatives Department - WCM Claims
      CalOptima
      505 City Parkway West
      Orange CA 92868

   b. An appeal claims submission file shall only include specific claims to be reconsidered.

   c. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

   d. CalOptima shall notify the eligible Health Network of file acceptance or rejection within three (3) business days after receipt of the appeal file.

      i. CalOptima may reject a file for any missing information or incorrect data.

      ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

e. CalOptima shall process an appeal and provide an eligible Health Network with the detailed report and payment, if applicable, on the following quarterly reimbursement period or within forty-five (45) business days after receipt of the appeal, whichever is later.

7. For each CCS-eligible Member in a given Measurement Period, CalOptima shall reimburse at one hundred percent (100%) of the repriced amount for the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members in excess of the thresholds which are:

   a. $17,000 for covered physician expenses; and

   b. $150,000 for covered hospital expenses.

8. CalOptima shall reconcile covered physician and covered hospital expenses separately.

9. CalOptima shall issue interim catastrophic payments to Health Networks in accordance with the timelines in Section II.J.2 of this Policy.

10. In the event of an extraordinary case(s) or significant cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

    a. Within forty-five (45) business days after receipt of the Health Network's request, CalOptima Claims Department will review the request and documentation and forward the recommendation to approve or deny the request to CalOptima Chief Executive Officer (CEO) and Chief Financial Officer (CFO).

    b. The CEO and CFO will make a final determination. CalOptima Finance Department will provide written notification of the final determination to the Health Network no later than sixty (60) business days after receipt of the Health Network's request. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next quarterly interim catastrophic payment or annual risk corridor calculation.

C. Retrospective Risk Corridor

1. After the December claims submission, CalOptima shall perform an annual retrospective risk corridor reconciliation for all Open Measurement Periods.

2. CalOptima shall validate and reprice the submitted claims, as described in Sections III.B.1 and III.B.2. of this Policy, based on the lesser of the CalOptima contracted and non-contracted rates or the amount actually paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical CPT code, HCPCS code, or other code as assigned by the DHCS. These allowable claims, as determined by CalOptima, shall represent the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members used in the retrospective risk corridor reconciliation. Similar to the interim catastrophic reimbursement, claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. CalOptima shall perform the retrospective risk corridor reconciliation for physician capitation and hospital capitation separately.

a. The baseline for the retrospective risk corridor reconciliation is an amount equal to the total Capitation Rate PMPM less the administrative and medical management loads PMPM developed by CalOptima, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services, multiplied by the number of CCS-eligible Members enrolled in the Health Networks during the applicable Measurement Period.

b. The net difference between the baseline and the qualified WCM medical expenses from Section III.C.2 of this Policy shall be applied to the risk corridor ranges approved by the BOD to determine an amount to be added or subtracted in the retrospective risk corridor reconciliation and referred to as risk corridor result in this Policy.

Threshold	CalOptima's Risk/Surplus Share
> 115%	95%
115%	90%
105%	75%
102%	50%
100%	0%
98%	50%
95%	75%
85%	90%
< 85%	100%

c. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A. and III.B. of this Policy respectively for the applicable Measurement Period results in a positive amount, the retrospective risk corridor reconciliation computes the risk corridor payment.

d. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A and III.B of this Policy respectively for the applicable Measurement Period results in a negative amount, the retrospective risk corridor reconciliation computes the risk corridor recoupment, which will be deducted from future initial Capitation Payments pursuant to Section III.C. of this Policy.

e. Administrative and medical management components of CCS reimbursement will be based on total reimbursement at the established percentage, inclusive of all reimbursement attributed to the Measurement Period regardless of when paid, including the initial Capitation Payment, interim catastrophic reimbursement, and retrospective risk corridor settlements. The established percentage shall be the administrative rate established by DHCS for the WCM program for the rate period, subject to a final reconciliation process once DHCS issues final rates for the rate period.

4. No later than March 31, CalOptima shall provide the retrospective risk corridor reconciliation to the Health Networks. If, upon review of the retrospective risk corridor reconciliation, the Health Networks object to the calculations or medical expenses determination, the Health Networks may follow the dispute process outlined in Section III.B.6. of this Policy within thirty (30) calendar days from the issuance of the retrospective risk corridor reconciliation.

5. If CalOptima does not receive any written objection from the Health Networks, CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the expiration of the review

period or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the expiration of the review period.

6. If CalOptima receives written objection from the Health Networks within the objection period, CalOptima shall review and provide responses to the Health Networks within forty-five (45) calendar days after the date of receipt of the written objection.

7. CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the date of issuance of the final retrospective risk corridor reconciliation or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the issuance of the final retrospective risk corridor reconciliation.

8. In the event of significant interim cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

   a. Within the time limit specified in Section III.B.10.a. of this Policy, CalOptima Claims Administration Department will review the request and documentation and forward the recommendation to approve or deny the request to the CEO and CFO.

   b. The CEO and CFO will make a final determination. CalOptima will notify the Health Network of the final determination in accordance with Section III.B.10.b. of this Policy. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next annual risk corridor calculation.

D. Medical expenses used in the reconciliation process for interim catastrophic reimbursement and retrospective risk corridor settlement shall be consistent with the financial risk in accordance with the Division of Financial Responsibility (DOFR) of the Health Network's Contract for Health Care Services.

E. In the event of an extraordinary case(s), where a claim is paid at rates greater than the CalOptima contracted or non-contracted rates, a Health Network may submit a formal written request for additional review. CalOptima will conduct further evaluation of such cases and determine whether any repricing adjustments are warranted and appropriate. Any approved repricing adjustments will be included in the next interim catastrophic payment or annual retrospective risk corridor reconciliation, whichever occurs first.

F. In the event that a Health Network is dissatisfied with the results of the interim catastrophic payment or annual retrospective risk corridor reconciliation after utilizing the dispute process set forth in this Policy, then the Health Network shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

G. Kaiser Reimbursement Process

1. CalOptima shall provide a monthly administrative capitation payment to Kaiser for enrolled CCS-eligible Members following the regular Medi-Cal capitation process and timeline.

2. Effective upon the implementation of Medi-Cal Rx, no sooner than January 1, 2021, ~~on the Department of Health Care Services (DHCS) approved Medi-Cal Pharmacy RX Benefit Transition program implementation date, no sooner than January 1, 2021~~pharmacy expenses for services rendered to enrolled CCS-eligible Kaiser Members, including Hepatitis C drug therapy, shall be excluded from this Policy and shall not be subject to reimbursement as described in Sections III.G.3 ~~and~~ through III.G.~~4~~5 of this ~~p~~Policy.

~~2.~~3. Kaiser shall submit a monthly report for covered hospital, physician, ancillary, facility and pharmacy expenses for services rendered to enrolled CCS-eligible Members in a format as agreed by CalOptima and Kaiser. Kaiser shall submit a report using CalOptima's proprietary format and file naming convention, or the equivalent, as agreed by CalOptima and Kaiser.

a. Reimbursement for Kaiser Hepatitis C drug therapy and Behavioral Health Therapy (BHT) claims for services provided to CCS-eligible Members shall be at the same supplemental rates at which such services are reimbursed for all other Kaiser Members, under a separate process. Therefore, all Hepatitis C drug therapy and BHT claims will be excluded from the monthly reconciliation described in Section III.~~F~~G.~~4~~5.

~~3.~~4. CalOptima shall validate and reprice the submitted claims based on:

a. Internal Kaiser pharmacy claims shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima contracted Pharmacy Network rate;

b. Physician, Hospital and Ancillary Kaiser system claims (services provided by those providers operating through the Kaiser System as defined in Kaiser's Contract for Health Care Services with CalOptima), shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule. CalOptima updates the CalOptima Medi-Cal Fee Schedule in accordance with CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule. Reimbursement will be based on the CalOptima Medi-Cal Fee Schedule in effect on the date of service;

c. Professional services provided by Kaiser system CCS-paneled providers shall be reimbursed at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule; and

d. For non-Kaiser system pharmacy and other services, CalOptima shall reprice the claims at the rate paid by Kaiser under its contract with the provider, or the rate negotiated and paid by Kaiser. Kaiser may elect to enter into a contract with CalOptima providers that have reciprocity requirements, in which case, CalOptima will reprice the claim at the contracted reciprocal rate.

~~4.~~5. Repricing Results and Reconciliation

a. CalOptima shall notify Kaiser of the results within thirty (30) business days after the date of CalOptima's receipt of the complete claims paid file.

b. Kaiser shall provide a rebuttal to, or acceptance of, the results within thirty (30) business days after the date of receipt of the results.

c. CalOptima, with the cooperation of Kaiser, shall perform a reconciliation of paid covered service expenses, if necessary.

d. CalOptima shall issue payment to Kaiser within fifteen (15) business days after receipt of the repricing acceptance or the completion of the reconciliation.

e. In the event that Kaiser is still dissatisfied with the repricing after rebuttal, reconciliation, and payment, then Kaiser shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

H. If a Health Network identifies an ~~o~~Overpayment of WCM payments, a Health Network shall return the ~~o~~Overpayment within sixty (60) calendar days after the date on which the ~~o~~Overpayment was

identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the ~~o~~Overpayment.

1. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the ~~o~~Overpayment no later than three (3) business days after receipt.

~~5.~~2. CalOptima shall coordinate with a Health Network on the process to return the ~~o~~Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy FF.1001: Capitation Payments
D. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
E. CalOptima Policy FF.1007: Health Network Reinsurance Coverage
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. DHCS All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayment to Providers

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/02/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
10/03/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2019	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	TBD	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	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 (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons 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.
CalOptima Direct-Administrative	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
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
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 Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.

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), 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.~~
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange
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, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled 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.
Measurement Period	Fiscal year July 1 to June 30.
Open Measurement Period	The measurement year will remain open until the third annual report is issued to health network
Overpayment	Any payment made by CalOptima to a ~~P~~provider to which the ~~P~~provider is not entitled to under Title XIX of the Social Security Act.

Term	Definition
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.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for enrolled Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Policy:	FF.4000
Title:	**Whole-Child Model – Financial Reimbursement for Capitated Health Networks**
Department:	CalOptima Administrative
Section:	Finance - Accounting
CEO Approval:	
Effective Date:	07/01/2019
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy establishes the reimbursement process for CalOptima to distribute Whole-Child Model (WCM) payments timely and accurately to Health Networks, including Health Maintenance Organizations (HMO), Physician Hospital Consortia (PHC), and Shared Risk Groups (SRG).

II. POLICY

A. CalOptima shall pay the Health Network in accordance with the Health Network's Contract for Health Care Services, the CalOptima Board of Directors (BOD)-approved payment methodology, and the terms and conditions of this Policy.

B. CalOptima's WCM reimbursement methodology for Health Networks is based on the number of California Children's Services (CCS) Program-eligible Members, as identified by the local CCS Program, enrolled in Health Networks during the applicable period.

C. If the local CCS Program identifies that an individual was not eligible for the CCS Program and retroactively terminates CCS eligibility, CalOptima shall recover payments made to the Health Network for such individual.

D. CalOptima Direct-Administrative (COD-A) is financially responsible for all Covered Services provided during a month in which a CCS-eligible Member has retroactive eligibility.

E. In accordance with CalOptima Policy FF.1007: Health Network Reinsurance Coverage, CalOptima shall exclude Members from the provision of reinsurance as of the effective date of the Member being CCS-eligible.

F. The Measurement Period for WCM payments is established by fiscal year (FY), July 1 to June 30. In accordance with Section II.J.3 of this Policy, CalOptima shall keep each Measurement Period (FY1) open for thirty (30) months after the end of each Measurement Period before the risk corridor reconciliation is considered finalized (e.g., Measurement Period FY 2019-20 (July 1, 2019 – June 30, 2020) will be finalized based on claims paid through December 31, 2022).

Back to Agenda Back to Item

G. CalOptima reimburses Health Networks, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), for services rendered to enrolled CCS-eligible Members based on a methodology that includes the following components described in this Policy:

1. Initial Capitation Payments;

2. Interim catastrophic payment; and

3. Retrospective risk corridor settlements.

H. CalOptima shall reimburse Kaiser for services rendered to enrolled CCS-eligible Members based on a methodology described in Section III.G. of this Policy.

I. CalOptima may adjust Health Network initial Capitation Payment rates subject to Department of Health Care Services (DHCS) funding updates for the Measurement Period.

J. The WCM payment timelines are:

1. Initial Capitation Payment: CalOptima shall pay monthly on or before the fifteenth (15th) calendar day of the month.

2. Interim catastrophic payment: CalOptima shall pay quarterly based on the refreshed data for each Measurement Period as follows:

CCS Eligible and Claims Incurred for Dates of Service	Claims Payment Period	Interim Catastrophic Calculation (Payment/ Recoupment) Date
July 1 – September 30, FY1	FY1 paid through September 30, FY1	No later than November 30, FY1
July 1 – December 31, FY1	FY1 paid through December 31, FY1	No later than February 28, FY1
July 1 – March 31, FY1	FY1 paid through March 31, FY1	No later than May 31, FY1
July 1 – June 30, FY1	FY1 paid through June 30, FY1	No later than August 31, FY2
July 1 – June 30, FY1	FY1 paid through September 30, FY2	No later than November 30, FY2

3. Retrospective risk corridor settlement: CalOptima shall pay annually based on the refreshed data for each Measurement Period as follows:

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 6 months: FY1 paid through December 31, FY2	No later than May 15, FY2
July 1 – June 30, FY1	Measurement Period plus 18 months: FY1 paid through December 31, FY3	No later than May 15, FY3

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 30 months (final): FY1 paid through December 31, FY4	No later than May 15, FY4

III. PROCEDURE

A. Initial Capitation Payment

1. CalOptima shall provide monthly Capitation Payments for CCS-eligible Members enrolled in the Health Networks at Capitation Rates per Member per month (PMPM) developed by CalOptima, approved by the BOD and set forth in the Health Network's Contract for Health Care Services.

2. CalOptima shall process the initial Capitation Payment in accordance with CalOptima Policy FF.1001: Capitation Payments. CalOptima shall issue one (1) payment that includes the initial Capitation Payment for CCS-eligible Members combined with the Capitation Payment for non-CCS eligible Members.

B. Interim Catastrophic Payment

1. Health Networks shall submit paid claims through the existing monthly External Decision Data submission for covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members monthly, by the fifteenth (15th) calendar day after the month ends for all Open Measurement Periods. Health Networks shall submit claims using CalOptima's proprietary format and file naming convention.

   a. An HMO, with the exception of Kaiser, shall submit claims for covered hospital and covered physician expenses;

   b. The Primary Physician Group of a PHC shall submit claims for covered physician expenses;

   c. The Primary Hospital of a PHC shall submit claims for covered hospital expenses; and

   d. An SRG shall submit claims for covered physician expenses.

2. CalOptima shall validate and reprice the submitted claims based on the CalOptima contracted and non-contracted rates following the lesser of the amount paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five (5)-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by DHCS. These allowable claims, as determined by CalOptima, shall represent the repriced WCM medical expenses used in the reconciliation process for the interim catastrophic reimbursement. Claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. Upon request, an eligible Health Network shall provide, within five (5) business days, detailed support for any individual claim for which billed charges are greater than or equal to ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits

(EOB), Remittance Advice Detail (RAD), and other information as requested by CalOptima. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

4. CalOptima shall notify an eligible Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for missing information or incorrect data. If CalOptima rejects a file, an eligible Health Network shall resubmit a corrected file no later than September 30, FY2 of the claims payment period pursuant to Section II.J.2 of this Policy. Any timely resubmission after the fifteenth (15th) of the month will be included in the subsequent month's process. A paid claims file initially submitted or a corrected file resubmitted by an eligible Health Network after the September 30, FY2 deadline will be processed in accordance with the requirements of the annual retrospective risk corridor reconciliation as set forth in Sections II.J.3 and III.C of this Policy.

5. For a complete claims paid file accepted by CalOptima, CalOptima shall notify an eligible Health Network of the results as follows:

   a. If CalOptima receives the file by the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of that month.

   b. If CalOptima receives the file after the fifteenth (15th) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of the subsequent month.

6. An eligible Health Network may appeal claim denials and payments within sixty (60) business days after the date of CalOptima's quarterly interim catastrophic payment remittance advice.

   a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima at:

      WCMReimb@caloptima.org

      Or by U.S. mail to:

      Attn: Coding Initiatives Department - WCM Claims
      CalOptima
      505 City Parkway West
      Orange CA 92868

   b. An appeal claims submission file shall only include specific claims to be reconsidered.

   c. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima.

   d. CalOptima shall notify the eligible Health Network of file acceptance or rejection within three (3) business days after receipt of the appeal file.

      i. CalOptima may reject a file for any missing information or incorrect data.

      ii. If CalOptima rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima.

e. CalOptima shall process an appeal and provide an eligible Health Network with the detailed report and payment, if applicable, on the following quarterly reimbursement period or within forty-five (45) business days after receipt of the appeal, whichever is later.

7. For each CCS-eligible Member in a given Measurement Period, CalOptima shall reimburse at one hundred percent (100%) of the repriced amount for the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members in excess of the thresholds which are:

   a. $17,000 for covered physician expenses; and

   b. $150,000 for covered hospital expenses.

8. CalOptima shall reconcile covered physician and covered hospital expenses separately.

9. CalOptima shall issue interim catastrophic payments to Health Networks in accordance with the timelines in Section II.J.2 of this Policy.

10. In the event of an extraordinary case(s) or significant cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

    a. Within forty-five (45) business days after receipt of the Health Network's request, CalOptima Claims Department will review the request and documentation and forward the recommendation to approve or deny the request to CalOptima Chief Executive Officer (CEO) and Chief Financial Officer (CFO).

    b. The CEO and CFO will make a final determination. CalOptima Finance Department will provide written notification of the final determination to the Health Network no later than sixty (60) business days after receipt of the Health Network's request. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next quarterly interim catastrophic payment or annual risk corridor calculation.

C. Retrospective Risk Corridor

1. After the December claims submission, CalOptima shall perform an annual retrospective risk corridor reconciliation for all Open Measurement Periods.

2. CalOptima shall validate and reprice the submitted claims, as described in Sections III.B.1 and III.B.2. of this Policy, based on the lesser of the CalOptima contracted and non-contracted rates or the amount actually paid for covered physician and hospital expenses. Repricing will be made at fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical CPT code, HCPCS code, or other code as assigned by the DHCS. These allowable claims, as determined by CalOptima, shall represent the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members used in the retrospective risk corridor reconciliation. Similar to the interim catastrophic reimbursement, claims paid by the Health Network at a higher rate than would be payable by CalOptima, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima would have paid under similar circumstances, not to exceed actual payments made.

3. CalOptima shall perform the retrospective risk corridor reconciliation for physician capitation and hospital capitation separately.

a. The baseline for the retrospective risk corridor reconciliation is an amount equal to the total Capitation Rate PMPM less the administrative and medical management loads PMPM developed by CalOptima, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services, multiplied by the number of CCS-eligible Members enrolled in the Health Networks during the applicable Measurement Period.

b. The net difference between the baseline and the qualified WCM medical expenses from Section III.C.2 of this Policy shall be applied to the risk corridor ranges approved by the BOD to determine an amount to be added or subtracted in the retrospective risk corridor reconciliation and referred to as risk corridor result in this Policy.

Threshold	CalOptima's Risk/Surplus Share
> 115%	95%
115%	90%
105%	75%
102%	50%
100%	0%
98%	50%
95%	75%
85%	90%
< 85%	100%

c. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A. and III.B. of this Policy respectively for the applicable Measurement Period results in a positive amount, the retrospective risk corridor reconciliation computes the risk corridor payment.

d. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A and III.B of this Policy respectively for the applicable Measurement Period results in a negative amount, the retrospective risk corridor reconciliation computes the risk corridor recoupment, which will be deducted from future initial Capitation Payments pursuant to Section III.C. of this Policy.

e. Administrative and medical management components of CCS reimbursement will be based on total reimbursement at the established percentage, inclusive of all reimbursement attributed to the Measurement Period regardless of when paid, including the initial Capitation Payment, interim catastrophic reimbursement, and retrospective risk corridor settlements. The established percentage shall be the administrative rate established by DHCS for the WCM program for the rate period, subject to a final reconciliation process once DHCS issues final rates for the rate period.

4. No later than March 31, CalOptima shall provide the retrospective risk corridor reconciliation to the Health Networks. If, upon review of the retrospective risk corridor reconciliation, the Health Networks object to the calculations or medical expenses determination, the Health Networks may follow the dispute process outlined in Section III.B.6. of this Policy within thirty (30) calendar days from the issuance of the retrospective risk corridor reconciliation.

5. If CalOptima does not receive any written objection from the Health Networks, CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the expiration of the review

period or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the expiration of the review period.

6. If CalOptima receives written objection from the Health Networks within the objection period, CalOptima shall review and provide responses to the Health Networks within forty-five (45) calendar days after the date of receipt of the written objection.

7. CalOptima shall pay the risk corridor payment within fifteen (15) calendar days after the date of issuance of the final retrospective risk corridor reconciliation or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the issuance of the final retrospective risk corridor reconciliation.

8. In the event of significant interim cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

   a. Within the time limit specified in Section III.B.10.a. of this Policy, CalOptima Claims Administration Department will review the request and documentation and forward the recommendation to approve or deny the request to the CEO and CFO.

   b. The CEO and CFO will make a final determination. CalOptima will notify the Health Network of the final determination in accordance with Section III.B.10.b. of this Policy. If and to the extent approved by CalOptima, the expedited cash funding will be included and reconciled in the next annual risk corridor calculation.

D. Medical expenses used in the reconciliation process for interim catastrophic reimbursement and retrospective risk corridor settlement shall be consistent with the financial risk in accordance with the Division of Financial Responsibility (DOFR) of the Health Network's Contract for Health Care Services.

E. In the event of an extraordinary case(s), where a claim is paid at rates greater than the CalOptima contracted or non-contracted rates, a Health Network may submit a formal written request for additional review. CalOptima will conduct further evaluation of such cases and determine whether any repricing adjustments are warranted and appropriate. Any approved repricing adjustments will be included in the next interim catastrophic payment or annual retrospective risk corridor reconciliation, whichever occurs first.

F. In the event that a Health Network is dissatisfied with the results of the interim catastrophic payment or annual retrospective risk corridor reconciliation after utilizing the dispute process set forth in this Policy, then the Health Network shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

G. Kaiser Reimbursement Process

1. CalOptima shall provide a monthly administrative capitation payment to Kaiser for enrolled CCS-eligible Members following the regular Medi-Cal capitation process and timeline.

2. Effective upon the implementation of Medi-Cal Rx, no sooner than January 1, 2021, pharmacy expenses for services rendered to enrolled CCS-eligible Kaiser Members, including Hepatitis C drug therapy, shall be excluded from this Policy and shall not be subject to reimbursement as described in Sections III.G.3 through III.G.5 of this Policy.

3. Kaiser shall submit a monthly report for covered hospital, physician, ancillary, facility and pharmacy expenses for services rendered to enrolled CCS-eligible Members in a format as agreed

by CalOptima and Kaiser. Kaiser shall submit a report using CalOptima's proprietary format and file naming convention, or the equivalent, as agreed by CalOptima and Kaiser.

a. Reimbursement for Kaiser Hepatitis C drug therapy and Behavioral Health Therapy (BHT) claims for services provided to CCS-eligible Members shall be at the same supplemental rates at which such services are reimbursed for all other Kaiser Members, under a separate process. Therefore, all Hepatitis C drug therapy and BHT claims will be excluded from the monthly reconciliation described in Section III.G.5.

4. CalOptima shall validate and reprice the submitted claims based on:

a. Internal Kaiser pharmacy claims shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima contracted Pharmacy Network rate;

b. Physician, Hospital and Ancillary Kaiser system claims (services provided by those providers operating through the Kaiser System as defined in Kaiser's Contract for Health Care Services with CalOptima), shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule. CalOptima updates the CalOptima Medi-Cal Fee Schedule in accordance with CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule. Reimbursement will be based on the CalOptima Medi-Cal Fee Schedule in effect on the date of service;

c. Professional services provided by Kaiser system CCS-paneled providers shall be reimbursed at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule; and

d. For non-Kaiser system pharmacy and other services, CalOptima shall reprice the claims at the rate paid by Kaiser under its contract with the provider, or the rate negotiated and paid by Kaiser. Kaiser may elect to enter into a contract with CalOptima providers that have reciprocity requirements, in which case, CalOptima will reprice the claim at the contracted reciprocal rate.

5. Repricing Results and Reconciliation

a. CalOptima shall notify Kaiser of the results within thirty (30) business days after the date of CalOptima's receipt of the complete claims paid file.

b. Kaiser shall provide a rebuttal to, or acceptance of, the results within thirty (30) business days after the date of receipt of the results.

c. CalOptima, with the cooperation of Kaiser, shall perform a reconciliation of paid covered service expenses, if necessary.

d. CalOptima shall issue payment to Kaiser within fifteen (15) business days after receipt of the repricing acceptance or the completion of the reconciliation.

e. In the event that Kaiser is still dissatisfied with the repricing after rebuttal, reconciliation, and payment, then Kaiser shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Policy HH.1101 CalOptima Provider Complaint.

H. If a Health Network identifies an Overpayment of WCM payments, 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's Accounting Department, in writing, of the reason for the Overpayment.

1. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the Overpayment no later than three (3) business days after receipt.

2. CalOptima shall coordinate with a Health Network on the process to return the Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy FF.1001: Capitation Payments
D. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
E. CalOptima Policy FF.1007: Health Network Reinsurance Coverage
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. DHCS All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayment to Providers

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/02/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
10/03/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2019	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	TBD	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	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 (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons 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.
CalOptima Direct-Administrative	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
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Capitation Rate	The per capita rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age, and gender.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
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 Cared Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
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Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange

Term	Definition
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, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members enrolled 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.
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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.
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Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for enrolled 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 December 3, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contacts
Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Brigette Gibb, Executive Director, Human Resources, (714) 246-8405

Recommended Action
Adopt Resolution Approving CalOptima's Updated Human Resources Policies:
1. GA.8012: Conflicts of Interest
2. GA.8018: Paid Time Off
3. GA.8019: Promotions and Transfers
4. GA.8020: 9/80 Work Schedule
5. GA.8026: Employee Referral Program
6. GA.8047: Reduction in Force

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.

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.8012: Conflicts of Interest	• Added statements reflecting requirements under applicable federal and state codes • Added guidelines to use to determine whether a real or apparent conflict of interest exists • Revised statement addressing handling of family member forms and data • Clarified obligations with reference to related gift policies • Expanded employee obligations to be aware of what outside activities, investments and/or positions might conflict with CalOptima employment	• This policy establishes the responsibility of all CalOptima employees to avoid conflicts of interest and incompatible outside activities. • Biennial review of the policy. • Revised content to clarify and reflect current practices.

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	Policy No./Name	Summary of Changes	Reason for Change
		• Updated requirement regarding disclosure of potential, suspected or actual conflicts • Revised statement regarding Form 700 & Supplement to Form 700 to reflect current processes • Revised statements regarding reporting conflict of interest and examples of activities requiring approval of the CEO • Added statements regarding other potential areas of conflicts • Moved statement regarding discussing possible conflicts to the procedure section. • Added statement outlining HR and employee procedures • Added references to related statutory requirements discussed in the policy • Attachment A Conflict of Interest Code, Exhibits A and B – updated position titles on list (added 20, deleted 3 & changed title 5).	
	GA.8018: Paid Time Off	• Added statement to allow the CEO to authorize use of one-time PTO of up to a maximum of eight (8) hours per employee per incident, in cases of local emergencies or unforeseen circumstances necessitating time off for the immediate protection, welfare and safety of the employee and/or CalOptima property. • Eliminated the requirement to use PTO in 15-minute increments as it does not align with how time is recorded at CalOptima. The timekeeping system records actual time worked (to the minute) and does not round up or down to the nearest 15 minutes. • Added statement to clarify that total hours accrued is based on the number of hours paid, prorated for employees who	• This policy provides managers and supervisors with appropriate guidelines to administer CalOptima's Paid Time Off (PTO) benefit. • Biennial review of the policy. • Revised content to clarify and reflect current practices.

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	Policy No./Name	Summary of Changes	Reason for Change
		work less than a full-time schedule, and calculated up to a maximum of 80 hours for the biweekly pay period. • Added a statement regarding supervisors having the authority to approve/deny PTO. • Added a statement that CalOptima will not be responsible for any expenses incurred by an employee if the request for PTO is not approved. • Revised Attachment A & B forms related PTO Donation Program to clarify requirements	
	GA.8019: Promotions and Transfers	• Defined criteria for exceptions to the requirement of being in the current position for a minimum of six (6) months. • Replaced definition of Performance Improvement Plan to be consistent with the definition in GA.8000 HR Glossary. • Replaced the previous Attachment A form with the Action Form currently used in HR.	• This policy establishes a consistent method of considering current employees for internal promotions and transfers. • Biennial review of the policy. • Revised content to clarify and reflect current practices.
	GA.8020: 9/80 Work Schedule	• Changed statement regarding positions not eligible for 9/80 from senior manager to Director level positions and above, unless approved by the Chief Executive Officer. • Other minor edits to be consistent with current practices.	• This policy outlines how CalOptima will administer an alternate workweek schedule commonly referred to as a 9/80 Work Schedule. • Biennial review of the policy. • Revised content to clarify and reflect current practices.
	GA.8026: Employee Referral Program	• Added criteria that defines when a temporary employee might be eligible for the referral bonus. • Revised the glossary term, Good Standing, to be consistent with the definition in GA.8000 HR Glossary.	• This policy provides for an opportunity for employees to receive an incentive for referring individuals to be hired by CalOptima. • Biennial review of the policy. • Revised content to clarify and reflect current practices.

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	Policy No./Name	Summary of Changes	Reason for Change
	GA.8047: Reduction in Force	• Minor edits to update referenced policy name and attachments with the current titles. • Other minor edits for consistency.	• This policy defines how CalOptima shall administer a Reduction in Force (RIF) program. • Biennial review of the policy. • Revised content to clarify and reflect current practices.

Fiscal Impact

The recommended action to adopt a resolution approving updated CalOptima Human Resources policies and procedures is budget neutral and has no additional fiscal impact.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 20-1203-01, Approve Updated Human Resources Policies
2. GA.8012: Conflicts of Interest (redlined and clean with Attachments)
3. GA.8018: Paid Time Off (redlined and clean with Attachments)
4. GA.8019: Promotions and Transfers (redlined and clean with Attachments)
5. GA.8020: 9/80 Work Schedule (redlined and clean with Attachments)
6. GA.8026: Employee Referral Program (redlined and clean)
7. GA.8047: Reduction in Force (redlined and clean with Attachments)

/s/ Richard Sanchez — *11/24/2020*

Authorized Signature — **Date**

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RESOLUTION NO. 20-1203-01

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.

NOW, THEREFORE, BE IT RESOLVED:

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

1. GA.8012: Conflicts of Interest
2. GA.8018: Paid Time Off
3. GA.8019: Promotions and Transfers
4. GA.8020: 9/80 Work Schedule
5. GA.8026: Employee Referral Program
6. GA.8047: Reduction in Force

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

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy:	GA.8012
Title:	**Conflicts of Interest**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	02/01/2000
Revised Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy ~~clarifies the responsibility of all~~establishes guidelines and standards for CalOptima ~~***employees***~~Employees to avoid conflicts of interest~~.~~ and incompatible outside activities

II. POLICY

A. CalOptima ~~***employees***~~Employees shall avoid ~~any~~anything that constitutes a real or apparent conflict between their personal interests and the interests of CalOptima.

B. ~~All~~ CalOptima ~~***employees***~~Employees shall avoid conflicts of interest and shall adhere to applicable state and federal laws and regulations, including, but not limited to:

1. California Government Code Section 81000 et seq., requiring all designated employees to comply with the reporting requirements in CalOptima's Conflict of Interest Code;

2. California Government Code Section 87100, prohibiting each CalOptima Employee from making, participating in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest;

3. California Government Code section 1090, prohibiting each CalOptima Employee from being financially interested in any contract made by the employee in his or her official capacity, and prohibiting each employee from being a purchaser at any sale or vendor at any purchase made by him or her in his or her official capacity.

4. California Government Code section 1126, which prohibits each CalOptima Employee from engaging in any employment, activity, or enterprise for compensation which is inconsistent, incompatible, in conflict with, or inimical to his or her duties as a local agency officer or employee or with the duties, functions, or responsibilities of CalOptima.

5. Title 42 of the United States Code section 1320-7b(b), prohibiting the knowing and willful offer, payment, solicitation or receipt of incentives or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the

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referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Title 42 of the Code of Federal Regulations section 460.68 regarding the disclosure and recusal requirement of the governing board for direct or indirect interest in any contract that supplies any administrative or care-related service or materials to PACE.

C. A conflict of interest exists in any situation in which an employee uses his or her position or association with CalOptima for personal or financial gain. The following guidelines are used to determine whether a real or apparent conflict of interest would exist.

1. *Avoidance of Unfair Competitive Advantage*. An employee's outside employment, consulting, or other business activity outside CalOptima may not influence decisions made by CalOptima in such a way as to give unfair competitive advantage to the employee's outside business activity.

2. *Use of Privileged or Official Information*. The use of privileged or official information for personal financial gain while employed with or after separating from employment is a type of conflict of interest and is prohibited. Privileged or official information is information that is known to an employee because of his or her employment with CalOptima but is not available to the public. The information covered under this provision includes, but is not limited to, personal health information (PHI), provider rates, personnel records, or proprietary information.

3. *Protection of Information Not Yet in Public Domain*. A CalOptima Employee acting as an independent consultant or as an employee of another organization may not use information, skills or knowledge obtained as a result of CalOptima employment, that is material or necessary to a current, in-progress, or proposed CalOptima project, that is proprietary to CalOptima and that is not yet in the public domain.

4. *Noncompetition with CalOptima*. An employee's outside employment or consulting activity must not compete with current or proposed CalOptima projects, programs or initiatives.

D. CalOptima Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima for member(s) of the employee's own family or for personal friends.

~~B.~~E. CalOptima Employees shall comply with the Code of Conduct and CalOptima Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima. Other than as permitted in CalOptima Policies, employees shall not receive gratuity, rebates, kickbacks, accommodation, or other unlawful consideration from any one provider, supplier, vendor, firm, or organization with whom CalOptima is currently doing or could potentially do business with. It is the responsibility of the employee to return any gift delivered to them and to notify the Clerk of the Board of such action.

~~C.~~F. ~~All~~ CalOptima ~~***employees***~~Employees shall be aware of what outside activities, investments, and/or positions may conflict with or detract from their effectiveness in employment with CalOptima, and shall ~~agree to~~ avoid such conflicts.

~~D.~~G. CalOptima ~~***employees***~~Employees shall ~~report~~ promptly disclose all potential, suspected, or actual conflicts of interest~~.~~ to CalOptima's Human Resources Department (HR)and shall personally withdraw from discussion, voting, or other decision-making process where an employee knows or has reason to know the employee has a real or apparent conflict of interest.

H. Designated CalOptima ~~***employees***~~Employees in those positions listed in the CalOptima Conflict of Interest Code shall complete ~~Form 700 Statement~~Statements of Economic Interests~~,~~ (FPPC Form 700) and ~~the~~a CalOptima Supplement to Form 700~~. Designated ***CalOptima employees*** include those employees who make decisions which foreseeably may have a substantial economic impact and are in positions designated~~ upon hire, annually, and upon termination of employment. If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.

~~E.~~ CalOptima ~~Conflict of Interest Code.~~

1. ~~All other ***CalOptima employees*** shall report~~Employees are required to promptly report any non-CalOptima job positions, positions held on non-profit/charitable organizations and/or their affiliations or interests in job-related businesses or organizations on an Employee Report of Outside Interest and/or Other Employment form provided by ~~Human Resources (HR).~~HR. CalOptima employees shall not participate in any of the following activities without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors):

   A. Perform work or render services for any Contractor/Vendor/Provider, association of Contractors/Vendors/Providers or other organizations with which CalOptima does business or which seek to do business with CalOptima;

   B. ~~Allowing~~Be a director, officer, or consultant of any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima does business or which seek to do business with CalOptima; or

   C. Permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima does business or which seek to do business with CalOptima.

I. Employees may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities.

J. As required in CalOptima's contract with the Department of Health Care Services (DHCS) and applicable state and federal laws and regulations, CalOptima shall avoid conflicts ~~to exist and interfere with one's responsibilities at CalOptima~~ of interest in the employment of current and former state officers and employees.

~~F.~~K. Failure to adhere to this Policy, including failure to promptly disclose any potential or actual conflicts or seek an exception may result in ~~discipline,~~corrective action, up to and including termination of employment and/or legal action. Conflicts that violate state or federal laws may result in regulatory or legal action, including possible fines and criminal prosecution.

~~G. ***CalOptima employees*** unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest should discuss it with their supervisor or HR for clarification.~~

III. PROCEDURE

A. ~~Human Resources~~HR shall:

1. ~~Inform~~Provide all new CalOptima ~~***employees*** regarding the terms and conditions~~Employees with a copy of this Policy and CalOptima's Code of Conduct.

2. Provide each designated CalOptima ~~***employees***~~employee with a copy of the Conflict of Interest Code and a link to the County of Orange's eDisclosure System to the Form 700 Statement of Economic Interests, to complete when assuming office, annually, and upon termination of employment. HR will also provide the Supplement to Form 700 upon hire and annually.

3. Make the Employee Report of Outside Interest and/or Other Employment form available to all CalOptima employees.

4. Collect and review the completed Supplement to Form 700 forms and/or Employee Report of Outside Interest and/or Other Employment Forms and obtain necessary approvals where required.

5. Not employ an individual holding a permanent or intermittent position in the State civil service or other appointed State official or an individual who was employed within the previous one (1) year as an appointee or civil service employee with DHCS, subject to certain exceptions which employment determination shall be made in conjunction with the Compliance Department.

B. All CalOptima ~~***employees***~~Employees shall:

1. ~~Read~~Review and comply with ~~the Conflict of Interest provisions and all applicable ***CalOptima employees'*** policies, including but not limited to, the~~ this Policy, CalOptima's Code of Conduct~~; and~~, and the CalOptima Employee Handbook;

2. ~~Report~~Avoid any actual or potential conflict between their personal interests and the interest of CalOptima;

~~2.~~3. Promptly report any job-related outside or personal ~~interest~~positions or interests on the Employee Report of Outside Interest and/or Other Employment form and submit such forms to HR.

4. Not make, or participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest.

5. Not offer, pay, solicit or receive an incentive or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Promptly report any suspected or apparent violation of this Policy to CalOptima's HR Department with detailed information sufficient for HR to investigate the issue and cooperate with any subsequent investigation.

7. CalOptima Employees unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest should discuss it with their supervisor or HR for clarification.

8. Upon being notified that an actual or apparent conflict exists, and an exception is not granted, the employee must promptly resolve the conflict by:

a. Terminating the outside activity;

b. Cooperating in reassignment, when appropriate or reasonable or;

c. Resigning from CalOptima.

C. Designated CalOptima ~~***employees***~~Employees in those positions listed in the CalOptima Conflict of Interest Code shall:

1. Upon assuming office, annually, and upon termination of employment, complete and submit a ~~Form 700~~ Statement of Economic Interests (FPPC Form 700) on the County of Orange eDisclosure system (~~https://cobcoi.ocgov.com/edisclosure/).~~ https://cobcoi.ocgov.com/edisclosure/); and

~~1.~~2. Complete a Supplement to Form 700 upon hire and annually.

IV. ATTACHMENT(S)

A. Conflict of Interest Code Exhibits A and B
B. Supplement to Form 700
C. Employee Report of Outside Interest and/or Other Employment Form

V. REFERENCE(S)

A. CalOptima Code of Conduct
B. CalOptima Conflict of Interest Code
C. CalOptima Employee Handbook
D. CalOptima Contract with the Department of Health Care Services (DHCS)
~~C.~~E. CalOptima Policy AA.1204: Gifts, Honoraria and Travel Payments (20200604-BOD)
~~D.~~F. CalOptima Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima (20200604-BOD)
~~E.~~G. Political Reform Act, Government Code §§81000-91014
~~F.~~H. Title 2, California Code of Regulations (C.C.R.), §§18730 ~~and 18730.1~~ *et seq.*
I. California Government Code, §§1090 *et. seq.*
J. California Government Code, §1126
K. Title 22, California Code of Regulations, §53600
L. Title 42, United States Code, §§1320a-7b(b)
M. Title 42, Code of Federal Regulations, §460.68

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/08/2009	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2000	GA.8012	Conflicts of Interest	Administrative
Revised	07/01/2007	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2017	GA.8012	Conflicts of Interest	Administrative
Revised	02/07/2019	GA.8012	Conflicts of Interest	Administrative
Revised	12/03/2020	GA.8012	Conflicts of Interest	Administrative

IX. GLOSSARY

Term	Definition
CalOptima ~~Employees~~Employee(s)	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns, CalOptima Board members, and applicable contractors and consultants.

Policy:	GA.8012
Title:	**Conflicts of Interest**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	02/01/2000
Revised Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines and standards for CalOptima Employees to avoid conflicts of interest and incompatible outside activities

II. POLICY

A. CalOptima Employees shall avoid anything that constitutes a real or apparent conflict between their personal interests and the interests of CalOptima.

B. CalOptima Employees shall avoid conflicts of interest and shall adhere to applicable state and federal laws and regulations, including, but not limited to:

1. California Government Code Section 81000 et seq., requiring all designated employees to comply with the reporting requirements in CalOptima's Conflict of Interest Code;

2. California Government Code Section 87100, prohibiting each CalOptima Employee from making, participating in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest;

3. California Government Code section 1090, prohibiting each CalOptima Employee from being financially interested in any contract made by the employee in his or her official capacity, and prohibiting each employee from being a purchaser at any sale or vendor at any purchase made by him or her in his or her official capacity.

4. California Government Code section 1126, which prohibits each CalOptima Employee from engaging in any employment, activity, or enterprise for compensation which is inconsistent, incompatible, in conflict with, or inimical to his or her duties as a local agency officer or employee or with the duties, functions, or responsibilities of CalOptima.

5. Title 42 of the United States Code section 1320-7b(b), prohibiting the knowing and willful offer, payment, solicitation or receipt of incentives or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the

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referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Title 42 of the Code of Federal Regulations section 460.68 regarding the disclosure and recusal requirement of the governing board for direct or indirect interest in any contract that supplies any administrative or care-related service or materials to PACE.

C. A conflict of interest exists in any situation in which an employee uses his or her position or association with CalOptima for personal or financial gain. The following guidelines are used to determine whether a real or apparent conflict of interest would exist.

1. *Avoidance of Unfair Competitive Advantage*. An employee's outside employment, consulting, or other business activity outside CalOptima may not influence decisions made by CalOptima in such a way as to give unfair competitive advantage to the employee's outside business activity.

2. *Use of Privileged or Official Information*. The use of privileged or official information for personal financial gain while employed with or after separating from employment is a type of conflict of interest and is prohibited. Privileged or official information is information that is known to an employee because of his or her employment with CalOptima but is not available to the public. The information covered under this provision includes, but is not limited to, personal health information (PHI), provider rates, personnel records, or proprietary information.

3. *Protection of Information Not Yet in Public Domain*. A CalOptima Employee acting as an independent consultant or as an employee of another organization may not use information, skills or knowledge obtained as a result of CalOptima employment, that is material or necessary to a current, in-progress, or proposed CalOptima project, that is proprietary to CalOptima and that is not yet in the public domain.

4. *Noncompetition with CalOptima*. An employee's outside employment or consulting activity must not compete with current or proposed CalOptima projects, programs or initiatives.

D. CalOptima Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima for member(s) of the employee's own family or for personal friends.

E. CalOptima Employees shall comply with the Code of Conduct and CalOptima Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima. Other than as permitted in CalOptima Policies, employees shall not receive gratuity, rebates, kickbacks, accommodation, or other unlawful consideration from any one provider, supplier, vendor, firm, or organization with whom CalOptima is currently doing or could potentially do business with. It is the responsibility of the employee to return any gift delivered to them and to notify the Clerk of the Board of such action.

F. CalOptima Employees shall be aware of what outside activities, investments, and/or positions may conflict with or detract from their effectiveness in employment with CalOptima, and shall avoid such conflicts.

G. CalOptima Employees shall promptly disclose all potential, suspected, or actual conflicts of interest to CalOptima's Human Resources Department (HR)and shall personally withdraw from discussion, voting, or other decision-making process where an employee knows or has reason to know the employee has a real or apparent conflict of interest.

H. Designated CalOptima Employees in those positions listed in the CalOptima Conflict of Interest Code shall complete Statements of Economic Interests (FPPC Form 700) and a CalOptima Supplement to Form 700 upon hire, annually, and upon termination of employment. If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.

1. CalOptima Employees are required to promptly report any non-CalOptima job positions, positions held on non-profit/charitable organizations and/or their affiliations or interests in job-related businesses or organizations on an Employee Report of Outside Interest and/or Other Employment form provided by HR. CalOptima employees shall not participate in any of the following activities without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors):

   a. Perform work or render services for any Contractor/Vendor/Provider, association of Contractors/Vendors/Providers or other organizations with which CalOptima does business or which seek to do business with CalOptima;

   b. Be a director, officer, or consultant of any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima does business or which seek to do business with CalOptima; or

   c. Permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima does business or which seek to do business with CalOptima.

I. Employees may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities.

J. As required in CalOptima's contract with the Department of Health Care Services (DHCS) and applicable state and federal laws and regulations, CalOptima shall avoid conflicts of interest in the employment of current and former state officers and employees.

K. Failure to adhere to this Policy, including failure to promptly disclose any potential or actual conflicts or seek an exception may result in corrective action, up to and including termination of employment and/or legal action. Conflicts that violate state or federal laws may result in regulatory or legal action, including possible fines and criminal prosecution.

III. PROCEDURE

A. HR shall:

1. Provide all new CalOptima Employees with a copy of this Policy and CalOptima's Code of Conduct.

2. Provide each designated CalOptima employee with a copy of the Conflict of Interest Code and a link to the County of Orange's eDisclosure System to the Form 700 Statement of Economic Interests, to complete when assuming office, annually, and upon termination of employment. HR will also provide the Supplement to Form 700 upon hire and annually.

3. Make the Employee Report of Outside Interest and/or Other Employment form available to all CalOptima employees.

4. Collect and review the completed Supplement to Form 700 forms and/or Employee Report of Outside Interest and/or Other Employment Forms and obtain necessary approvals where required.

5. Not employ an individual holding a permanent or intermittent position in the State civil service or other appointed State official or an individual who was employed within the previous one (1) year as an appointee or civil service employee with DHCS, subject to certain exceptions which employment determination shall be made in conjunction with the Compliance Department.

B. All CalOptima Employees shall:

1. Review and comply with this Policy, CalOptima's Code of Conduct, and the CalOptima Employee Handbook;

2. Avoid any actual or potential conflict between their personal interests and the interest of CalOptima;

3. Promptly report any job-related outside or personal positions or interests on the Employee Report of Outside Interest and/or Other Employment form and submit such forms to HR.

4. Not make, or participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest.

5. Not offer, pay, solicit or receive an incentive or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Promptly report any suspected or apparent violation of this Policy to CalOptima's HR Department with detailed information sufficient for HR to investigate the issue and cooperate with any subsequent investigation.

7. CalOptima Employees unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest should discuss it with their supervisor or HR for clarification.

8. Upon being notified that an actual or apparent conflict exists, and an exception is not granted, the employee must promptly resolve the conflict by:

   a. Terminating the outside activity;

   b. Cooperating in reassignment, when appropriate or reasonable or;

   c. Resigning from CalOptima.

C. Designated CalOptima Employees in those positions listed in the CalOptima Conflict of Interest Code shall:

1. Upon assuming office, annually, and upon termination of employment, complete and submit a Statement of Economic Interests (FPPC Form 700) on the County of Orange eDisclosure system (https://cobcoi.ocgov.com/edisclosure/); and

2. Complete a Supplement to Form 700 upon hire and annually.

IV. ATTACHMENT(S)

A. Conflict of Interest Code Exhibits A and B
B. Supplement to Form 700
C. Employee Report of Outside Interest and/or Other Employment Form

V. REFERENCE(S)

A. CalOptima Code of Conduct
B. CalOptima Conflict of Interest Code
C. CalOptima Employee Handbook
D. CalOptima Contract with the Department of Health Care Services (DHCS)
E. CalOptima Policy AA.1204: Gifts, Honoraria and Travel Payments (20200604-BOD)
F. CalOptima Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima (20200604-BOD)
G. Political Reform Act, Government Code §§81000-91014
H. Title 2, California Code of Regulations (C.C.R.), §§18730 *et seq.*
I. California Government Code, §§1090 *et. seq.*
J. California Government Code, §1126
K. Title 22, California Code of Regulations, §53600
L. Title 42, United States Code, §§1320a-7b(b)
M. Title 42, Code of Federal Regulations, §460.68

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/08/2009	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2000	GA.8012	Conflicts of Interest	Administrative
Revised	07/01/2007	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2017	GA.8012	Conflicts of Interest	Administrative
Revised	02/07/2019	GA.8012	Conflicts of Interest	Administrative
Revised	12/03/2020	GA.8012	Conflicts of Interest	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Employee(s)	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns, CalOptima Board members, and applicable contractors and consultants.

Conflict of Interest Code
EXHIBIT A

Entity: **Other Misc. Authorities, Districts and Commissions**
Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Assistant Director	OC-41	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Associate Director, Customer Service	OC-41	COB	Unchanged
Associate Director, Information Services	OC-08	COB	Unchanged
Associate Director, Provider Network	OC-41	COB	Unchanged
Buyer	OC-01	COB	Unchanged
Buyer, Int.	OC-01	COB	Unchanged
Buyer, Sr.	OC-01	COB	Unchanged
Chief Counsel	OC-01	COB	Unchanged
Chief Executive Officer	OC-01	COB	Unchanged
Chief Financial Officer	OC-01	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Chief Information Officer	OC-01	COB	Unchanged
Chief Medical Officer	OC-01	COB	Unchanged
Chief Operating Officer	OC-01	COB	Unchanged
Clerk of the Board	OC-06	COB	Unchanged
Clinical Pharmacist	OC-20	COB	Unchanged
Consultant	~~OC-30~~OC-01	Agency	Category Changed
Contract Administrator	OC-06	COB	Unchanged
Contracts Manager	OC-06	COB	Unchanged
Contracts Manager, Sr.	OC-06	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Contracts Specialist	OC-06	COB	Unchanged
Contracts Specialist, Int.	OC-06	COB	Unchanged
Contracts Specialist, Sr.	OC-06	COB	Unchanged
Controller	OC-01	COB	Unchanged
Deputy Chief Counsel	OC-01	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Deputy Chief Medical Officer	OC-01	COB	Unchanged
Deputy Clerk of the Board	OC-01	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Director, Accounting	OC-01	COB	Unchanged
Director, Applications Management	OC-08	COB	Unchanged
Director, Audit and Oversight	OC-01	COB	Unchanged
Director, Behavioral Health Services	OC-41	COB	Unchanged
Director, Budget & Procurement	OC-01	COB	Unchanged
Director, Business Development	OC-41	COB	Unchanged
Director, Business Integration	OC-41	COB	Unchanged
Director, Case Management	OC-41	COB	Unchanged
Director, Claims Administration	OC-41	COB	Unchanged
Director, Clinical Outcomes	OC-01	COB	Unchanged
Director, Clinical Pharmacy	OC-01	COB	Unchanged
Director, Coding Initiatives	OC-06	COB	Unchanged
Director, Communications	OC-13	COB	Unchanged
Director, Community Relations	OC-41	COB	Unchanged
Director, Configuration & Coding	OC-06	COB	Unchanged
Director, Contracting	OC-01	COB	Unchanged
Director, COREC	OC-08	COB	Unchanged
Director, Customer Service	OC-41	COB	Unchanged
Director, Electronic Business	OC-06	COB	Unchanged
Director, Enterprise Analytics	OC-06	COB	Unchanged
Director, Facilities	OC-41	COB	Unchanged
Director, Finance & Procurement	OC-01	COB	Unchanged
Director, Financial Analysis	OC-01	COB	Unchanged
Director, Financial Compliance	OC-01	COB	Unchanged
Director, Fraud, Waste & Abuse and Privacy	OC-01	COB	Unchanged
Director, Government Affairs	OC-41	COB	Unchanged
Director, Grievance & Appeals	OC-41	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Director, Population Health Management~~Director, Health Education & Disease Management~~	OC-41	COB	Title change 20190801
Reason: Title changed due to change in department name			
Director, Health Services	OC-41	COB	Unchanged
Director, Human Resources	OC-11	COB	Unchanged
Director, Information Services	OC-08	COB	Unchanged
Director, Long Term Support Services	OC-41	COB	Unchanged
Director, Medi-Cal Plan Operations	OC-41	COB	Unchanged
Director, Network Management	OC-41	COB	Unchanged
Director, OneCare Operations	OC-41	COB	Unchanged
Director, Organizational Training & Education	OC-11	COB	Unchanged
Director, PACE Program	OC-41	COB	Unchanged
Director, Process Excellence	OC-41	COB	Unchanged
Director, Program Implementation	OC-41	COB	Unchanged
Director, Project Management	OC-41	COB	Unchanged
Director, Provider Data Quality	OC-41	COB	Unchanged
Director, Provider Services	OC-41	COB	Unchanged
Director, Public Policy	OC-41	COB	Unchanged
Director, Quality (LTSS)	OC-41	COB	Unchanged
Director, Quality Analytics	OC-06	COB	Unchanged
Director, Quality Improvement	OC-41	COB	Unchanged
Director, Regulatory Affairs and Compliance	OC-01	COB	Unchanged
Director, Strategic Development	OC-41	COB	Unchanged
Director, Systems Development	OC-08	COB	Unchanged
Director, Utilization Management	OC-41	COB	Unchanged
Director, Vendor Management	OC-01	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Enterprise Analytics Manager	OC-06	COB	Unchanged
Executive Director, Behavioral Health Integration	OC-41	COB	Unchanged
Executive Director, Clinical Operations	OC-01	COB	Unchanged
Executive Director, Compliance	OC-01	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Executive Director, Human Resources	OC-01	COB	Unchanged
Executive Director, Network Operations	OC-01	COB	Unchanged
Executive Director, Operations	OC-01	COB	Unchanged
Executive Director, Program Implementation	OC-01	COB	Unchanged
Executive Director, Public Affairs	OC-01	COB	Unchanged
Executive Director, Quality & Population Health Management	OC-01	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
~~Executive Director, Quality Analytics~~	~~OC-06~~	~~COB~~	
Reason: Deleting position since it no longer exists in CalOptima			
Financial Analyst	OC-01	COB	Unchanged
Financial Analyst, Sr.	OC-01	COB	Unchanged
Financial Reporting Analyst	OC-01	COB	Unchanged
Litigation Support Specialist	OC-41	COB	Unchanged
Manager, Accounting	OC-01	COB	Unchanged
Manager, Actuary	OC-01	COB	Unchanged
Manager, Applications Management	OC-08	COB	Unchanged
Manager, Audit and Oversight	OC-01	COB	Unchanged
Manager, Behavioral Health	OC-41	COB	Unchanged
Manager, Business Integration	OC-06	COB	Unchanged
Manager, Case Management	OC-41	COB	Unchanged
Manager, Claims	OC-41	COB	Unchanged
Manager, Clinic Operations	OC-06	COB	Unchanged
Manager, Clinical Pharmacists	OC-20	COB	Unchanged
Manager, Coding Quality	OC-06	COB	Unchanged
Manager, Communications	OC-13	COB	Unchanged
Manager, Community Relations	OC-06	COB	Unchanged
Manager, Contracting	OC-41	COB	Unchanged
Manager, Creative Branding	OC-13	COB	Unchanged
Manager, Cultural & Linguistics	OC-06	COB	Unchanged
Manager, Customer Service	OC-41	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Manager, Decision Support	OC-06	COB	Unchanged
Manager, Population Health Management~~Manager, Disease Management~~	OC-41	COB	Title change 20190801
Reason: Title changed due to change in department name			
Manager, Electronic Business	OC-06	COB	Unchanged
Manager, Employment Services	OC-11	COB	Unchanged
Manager, Encounters	OC-06	COB	Unchanged
Manager, Environmental Health & Safety	OC-06	COB	Unchanged
Manager, Facilities	OC-41	COB	Unchanged
Manager, Finance	OC-01	COB	Unchanged
Manager, Financial Analysis	OC-01	COB	Unchanged
Manager, Government Affairs	OC-41	COB	Unchanged
Manager, Grievance and Appeals	OC-41	COB	Unchanged
Manager, Health Education	OC-41	COB	Unchanged
Manager, HEDIS	OC-06	COB	Unchanged
Manager, Human Resources	OC-11	COB	Unchanged
Manager, Information Services	OC-08	COB	Unchanged
Manager, Information Technology	OC-08	COB	Unchanged
Manager, Integration Government Liaison	OC-41	COB	Unchanged
Manager, Long Term Support Services	OC-41	COB	Unchanged
Manager, Marketing and Enrollment (PACE)	OC-06	COB	Unchanged
Reason: Title changed to designate department			
Manager, Marketing & Outreach	OC-06	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Manager, Medical Data Management	OC-06	COB	Unchanged
Manager, Medi-Cal Program Operations	OC-41	COB	Unchanged
Manager, Member Liaison Program	OC-41	COB	Unchanged
Manager, Member Outreach & Education	OC-41	COB	Unchanged
Manager, Member Outreach, Education and Provider Relations	OC-41	COB	Unchanged
Manager, MSSP	OC-41	COB	Unchanged
Manager, Process Excellence	OC-41	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Manager, Program Implementation	OC-06	COB	Unchanged
Manager, Project Management	OC-06	COB	Unchanged
Manager, Provider Data Management Services	OC-41	COB	Unchanged
Manager, Provider Network	OC-41	COB	Unchanged
Manager, Provider Relations	OC-41	COB	Unchanged
Manager, Provider Services	OC-41	COB	Unchanged
Manager, Purchasing	OC-01	COB	Unchanged
Manager, QI Initiatives	OC-41	COB	Unchanged
Manager, Quality Analytics	OC-06	COB	Unchanged
Manager, Quality Improvement	OC-41	COB	Unchanged
Manager, Regulatory Affairs and Compliance	OC-41	COB	Unchanged
Manager, Reporting & Financial Compliance	OC-01	COB	Unchanged
Manager, Strategic Development	OC-41	COB	Unchanged
Manager, Strategic Operations	OC-41	COB	Unchanged
Manager, Systems Development	OC-08	COB	Unchanged
Manager, Utilization Management	OC-06	COB	Unchanged
Medical Case Manager	OC-41	COB	Unchanged
Medical Case Manager (LVN)	OC-41	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Medical Director	OC-01	COB	Unchanged
Medical Services Case Manager	OC-41~~OC-01~~	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Nurse Practitioner (PACE)	OC-41~~OC-01~~	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
OneCare Operations Manager	OC-41	COB	Unchanged
Pharmacy Resident	OC-20	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Pharmacy Services Specialist	OC-20	COB	Unchanged
Pharmacy Services Specialist, Int.	OC-20	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Pharmacy Services Specialist, Sr.	OC-20	COB	Unchanged
Policy Advisor, Sr.	OC-41-	COB-	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Privacy Manager	OC-41	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Privacy Officer	OC-41	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Process Excellence Manager	OC-41	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Program Manager	OC-06	COB	Unchanged
Program Manager Sr.	OC-06	COB	Unchanged
Project Manager	OC-06	COB	Unchanged
Project Manager, Lead	OC-06	COB	Unchanged
Project Manager, Sr.	OC-06	COB	Unchanged
QI Nurse Specialist (RN or LVN)	OC-06	COB	Unchanged
Regulatory Affairs and Compliance Analyst	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Analyst Sr	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Lead	OC-41	COB	Unchanged
RN (PACE)	OC-41	COB	Added- New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Security Officer	OC-41	COB	Added- New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Senior Manager, Government Affairs	OC-06	COB	Unchanged
Special Counsel	OC-01	COB	Unchanged
Sr. Director Regulatory Affairs and Compliance	OC-01	COB	Unchanged
Sr. Manager Financial Analysis	OC-01	COB	Unchanged
Sr. Manager Human Resources	OC-11	COB	Unchanged
Sr. Manager Information Services	OC-08	COB	Unchanged
Sr. Manager Provider Network	OC-41	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Staff Attorney	OC-01	COB	Unchanged
Staff Attorney, Sr.	OC-01	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Supervisor, Accounting	OC-01	COB	Unchanged
Supervisor, Audit and Oversight	OC-01	COB	Unchanged
Supervisor, Behavioral Health	OC-41	COB	Unchanged
Supervisor, Budgeting	OC-01	COB	Unchanged
Supervisor, Case Management	OC-41	COB	Unchanged
Supervisor, Claims	OC-06	COB	Unchanged
Supervisor, Coding Initiatives	OC-06	COB	Unchanged
Supervisor, Credentialing	OC-41	COB	Unchanged
Supervisor, Customer Service	OC-06	COB	Unchanged
Supervisor, Data Entry	OC-06	COB	Unchanged
Supervisor, Day Center (PACE)	OC-06	COB	Unchanged
Supervisor, Population Health Management~~Supervisor, Disease Management~~	OC-41	COB	Title change 20190801
Reason: Title changed due to change in department name			
Supervisor, Dietary Services (Pace)	OC-41	COB	Unchanged
Supervisor, Encounters	OC-06	COB	Added-New 20190801
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Supervisor, Facilities	OC-41	COB	Unchanged
Supervisor, Finance	OC-01	COB	Unchanged
Supervisor, Grievance and Appeals	OC-41	COB	Unchanged
Supervisor, Health Education	OC-06	COB	Unchanged
Supervisor, Information Services	OC-08	COB	Unchanged
Supervisor, Long Term Support Services	OC-41	COB	Unchanged
Supervisor, Member Outreach and Education	OC-06	COB	Added New 20200903
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list			
Supervisor, MSSP	OC-06	COB	Unchanged
Supervisor, Nursing Services (PACE)	OC-41	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Supervisor, OneCare Customer Service	OC-06	COB	Unchanged
Supervisor, Payroll	OC-06	COB	Unchanged
Supervisor, Pharmacist	OC-20	COB	Unchanged
Supervisor, Provider Enrollment	OC-06	COB	Unchanged
Supervisor, Provider Relations	OC-41	COB	Unchanged
Supervisor, Quality Analytics	OC-06	COB	Unchanged
Supervisor, Quality Improvement	OC-41	COB	Unchanged
Supervisor, Regulatory Affairs and Compliance	OC-41~~OC-06~~	COB	Unchanged
Supervisor, Social Work (PACE)	OC-41	COB	Unchanged
Supervisor, Systems Development	OC-08	COB	Unchanged
Supervisor, Therapy Services (PACE)	OC-41	COB	Unchanged
Supervisor, Utilization Management	~~OC-06~~	COB	Unchanged

Total: 221

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code, but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB
Chief Executive Officer	Files with	COB
Chief Financial Officer	Files with	COB
Member of the Board of Directors	Files with	COB

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

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Entity: **Other Misc. Authorities, Districts and Commissions**
Agency: **CalOptima**

Disclosure Category	Disclosure Description	Status
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*..	Unchanged
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).	Unchanged
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.	Unchanged
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.	Unchanged
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.	Unchanged
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.	Unchanged
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.	Unchanged

Disclosure Category	Disclosure Description	Status
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged

Grand Total: 9

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Entity: **Other Misc. Authorities, Districts and Commissions**
Agency: **CalOptima**

Position	Disclosure Category	Files With
Assistant Director	OC-41	COB
Associate Director, Customer Service	OC-41	COB
Associate Director, Information Services	OC-08	COB
Associate Director, Provider Network	OC-41	COB
Buyer	OC-01	COB
Buyer, Int.	OC-01	COB
Buyer, Sr.	OC-01	COB
Chief Counsel	OC-01	COB
Chief Executive Officer	OC-01	COB
Chief Financial Officer	OC-01	COB
Chief Information Officer	OC-01	COB
Chief Medical Officer	OC-01	COB
Chief Operating Officer	OC-01	COB
Clerk of the Board	OC-06	COB
Clinical Pharmacist	OC-20	COB
Consultant	OC-01	Agency
Contract Administrator	OC-06	COB
Contracts Manager	OC-06	COB
Contracts Manager, Sr.	OC-06	COB
Contracts Specialist	OC-06	COB
Contracts Specialist, Int.	OC-06	COB
Contracts Specialist, Sr.	OC-06	COB
Controller	OC-01	COB
Deputy Chief Counsel	OC-01	COB
Deputy Chief Medical Officer	OC-01	COB
Deputy Clerk of the Board	OC-01	COB
Director, Accounting	OC-01	COB
Director, Applications Management	OC-08	COB

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Position	Disclosure Category	Files With
Director, Audit and Oversight	OC-01	COB
Director, Behavioral Health Services	OC-41	COB
Director, Budget & Procurement	OC-01	COB
Director, Business Development	OC-41	COB
Director, Business Integration	OC-41	COB
Director, Case Management	OC-41	COB
Director, Claims Administration	OC-41	COB
Director, Clinical Outcomes	OC-01	COB
Director, Clinical Pharmacy	OC-01	COB
Director, Coding Initiatives	OC-06	COB
Director, Communications	OC-13	COB
Director, Community Relations	OC-41	COB
Director, Configuration & Coding	OC-06	COB
Director, Contracting	OC-01	COB
Director, COREC	OC-08	COB
Director, Customer Service	OC-41	COB
Director, Electronic Business	OC-06	COB
Director, Enterprise Analytics	OC-06	COB
Director, Facilities	OC-41	COB
Director, Finance & Procurement	OC-01	COB
Director, Financial Analysis	OC-01	COB
Director, Financial Compliance	OC-01	COB
Director, Fraud, Waste & Abuse and Privacy	OC-01	COB
Director, Government Affairs	OC-41	COB
Director, Grievance & Appeals	OC-41	COB
Director, Health Services	OC-41	COB
Director, Human Resources	OC-11	COB
Director, Information Services	OC-08	COB
Director, Long Term Support Services	OC-41	COB
Director, Medi-Cal Plan Operations	OC-41	COB

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Position	Disclosure Category	Files With
Director, Network Management	OC-41	COB
Director, OneCare Operations	OC-41	COB
Director, Organizational Training & Education	OC-11	COB
Director, PACE Program	OC-41	COB
Director, Population Health Management	OC-41	COB
Director, Process Excellence	OC-41	COB
Director, Program Implementation	OC-41	COB
Director, Project Management	OC-41	COB
Director, Provider Data Quality	OC-41	COB
Director, Provider Services	OC-41	COB
Director, Public Policy	OC-41	COB
Director, Quality (LTSS)	OC-41	COB
Director, Quality Analytics	OC-06	COB
Director, Quality Improvement	OC-41	COB
Director, Regulatory Affairs and Compliance	OC-01	COB
Director, Strategic Development	OC-41	COB
Director, Systems Development	OC-08	COB
Director, Utilization Management	OC-41	COB
Director, Vendor Management	OC-01	COB
Enterprise Analytics Manager	OC-06	COB
Executive Director, Behavioral Health Integration	OC-41	COB
Executive Director, Clinical Operations	OC-01	COB
Executive Director, Compliance	OC-01	COB
Executive Director, Human Resources	OC-01	COB
Executive Director, Network Operations	OC-01	COB
Executive Director, Operations	OC-01	COB
Executive Director, Program Implementation	OC-01	COB
Executive Director, Public Affairs	OC-01	COB
Executive Director, Quality & Population Health Management	OC-01	COB
Financial Analyst	OC-01	COB

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Position	Disclosure Category	Files With
Financial Analyst, Sr.	OC-01	COB
Financial Reporting Analyst	OC-01	COB
Litigation Support Specialist	OC-41	COB
Manager, Accounting	OC-01	COB
Manager, Actuary	OC-01	COB
Manager, Applications Management	OC-08	COB
Manager, Audit and Oversight	OC-01	COB
Manager, Behavioral Health	OC-41	COB
Manager, Business Integration	OC-06	COB
Manager, Case Management	OC-41	COB
Manager, Claims	OC-41	COB
Manager, Clinic Operations	OC-06	COB
Manager, Clinical Pharmacists	OC-20	COB
Manager, Coding Quality	OC-06	COB
Manager, Communications	OC-13	COB
Manager, Community Relations	OC-06	COB
Manager, Contracting	OC-41	COB
Manager, Creative Branding	OC-13	COB
Manager, Cultural & Linguistics	OC-06	COB
Manager, Customer Service	OC-41	COB
Manager, Decision Support	OC-06	COB
Manager, Electronic Business	OC-06	COB
Manager, Employment Services	OC-11	COB
Manager, Encounters	OC-06	COB
Manager, Environmental Health & Safety	OC-06	COB
Manager, Facilities	OC-41	COB
Manager, Finance	OC-01	COB
Manager, Financial Analysis	OC-01	COB
Manager, Government Affairs	OC-41	COB
Manager, Grievance and Appeals	OC-41	COB

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Position	Disclosure Category	Files With
Manager, Health Education	OC-41	COB
Manager, HEDIS	OC-06	COB
Manager, Human Resources	OC-11	COB
Manager, Information Services	OC-08	COB
Manager, Information Technology	OC-08	COB
Manager, Integration Government Liaison	OC-41	COB
Manager, Long Term Support Services	OC-41	COB
Manager, Marketing and Enrollment (PACE)	OC-06	COB
Manager, Marketing & Outreach	OC-06	COB
Manager, Medical Data Management	OC-06	COB
Manager, Medi-Cal Program Operations	OC-41	COB
Manager, Member Liaison Program	OC-41	COB
Manager, Member Outreach & Education	OC-41	COB
Manager, Member Outreach, Education and Provider Relations	OC-41	COB
Manager, MSSP	OC-41	COB
Manager, Population Health Management	OC-41	COB
Manager, Process Excellence	OC-41	COB
Manager, Program Implementation	OC-06	COB
Manager, Project Management	OC-06	COB
Manager, Provider Data Management Services	OC-41	COB
Manager, Provider Network	OC-41	COB
Manager, Provider Relations	OC-41	COB
Manager, Provider Services	OC-41	COB
Manager, Purchasing	OC-01	COB
Manager, QI Initiatives	OC-41	COB
Manager, Quality Analytics	OC-06	COB
Manager, Quality Improvement	OC-41	COB
Manager, Regulatory Affairs and Compliance	OC-41	COB
Manager, Reporting & Financial Compliance	OC-01	COB
Manager, Strategic Development	OC-41	COB

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EXHIBIT A

Position	Disclosure Category	Files With
Manager, Strategic Operations	OC-41	COB
Manager, Systems Development	OC-08	COB
Manager, Utilization Management	OC-06	COB
Medical Case Manager	OC-41	COB
Medical Case Manager (LVN)	OC-41	COB
Medical Director	OC-01	COB
Medical Services Case Manager	OC-41	COB
Nurse Practitioner (PACE)	OC-41	COB
OneCare Operations Manager	OC-41	COB
Pharmacy Resident	OC-20	COB
Pharmacy Services Specialist	OC-20	COB
Pharmacy Services Specialist, Int.	OC-20	COB
Pharmacy Services Specialist, Sr.	OC-20	COB
Policy Advisor, Sr.	OC-41	COB
Privacy Manager	OC-41	COB
Privacy Officer	OC-41	COB
Process Excellence Manager	OC-41	COB
Program Manager	OC-06	COB
Program Manager, Sr.	OC-06	COB
Project Manager	OC-06	COB
Project Manager, Lead	OC-06	COB
Project Manager, Sr.	OC-06	COB
QI Nurse Specialist (RN or LVN)	OC-06	COB
Regulatory Affairs and Compliance Analyst	OC-41	COB
Regulatory Affairs and Compliance Analyst, Sr.	OC-41	COB
Regulatory Affairs and Compliance, Lead	OC-41	COB
RN (PACE)	OC-41	COB
Security Officer	OC-41	COB
Senior Manager, Government Affairs	OC-06	COB
Special Counsel	OC-01	COB

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Position	Disclosure Category	Files With
Sr. Director, Regulatory Affairs and Compliance	OC-01	COB
Sr. Manager, Financial Analysis	OC-01	COB
Sr. Manager, Human Resources	OC-11	COB
Sr. Manager, Information Services	OC-08	COB
Sr. Manager, Provider Network	OC-41	COB
Staff Attorney	OC-01	COB
Staff Attorney, Sr.	OC-01	COB
Supervisor, Accounting	OC-01	COB
Supervisor, Audit and Oversight	OC-01	COB
Supervisor, Behavioral Health	OC-41	COB
Supervisor, Budgeting	OC-01	COB
Supervisor, Case Management	OC-41	COB
Supervisor, Claims	OC-06	COB
Supervisor, Coding Initiatives	OC-06	COB
Supervisor, Credentialing	OC-41	COB
Supervisor, Customer Service	OC-06	COB
Supervisor, Data Entry	OC-06	COB
Supervisor, Day Center (PACE)	OC-06	COB
Supervisor, Dietary Services (PACE)	OC-41	COB
Supervisor, Encounters	OC-06	COB
Supervisor, Facilities	OC-41	COB
Supervisor, Finance	OC-01	COB
Supervisor, Grievance and Appeals	OC-41	COB
Supervisor, Health Education	OC-06	COB
Supervisor, Information Services	OC-08	COB
Supervisor, Long Term Support Services	OC-41	COB
Supervisor, Member Outreach and Education	OC-06	COB
Supervisor, MSSP	OC-06	COB
Supervisor, Nursing Services (PACE)	OC-41	COB
Supervisor, OneCare Customer Service	OC-06	COB

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Conflict of Interest Code
EXHIBIT A

Position	Disclosure Category	Files With
Supervisor, Payroll	OC-06	COB
Supervisor, Pharmacist	OC-20	COB
Supervisor, Population Health Management	OC-41	COB
Supervisor, Provider Enrollment	OC-06	COB
Supervisor, Provider Relations	OC-41	COB
Supervisor, Quality Analytics	OC-06	COB
Supervisor, Quality Improvement	OC-41	COB
Supervisor, Regulatory Affairs and Compliance	OC-41	COB
Supervisor, Social Work (PACE)	OC-41	COB
Supervisor, Systems Development	OC-08	COB
Supervisor, Therapy Services (PACE)	OC-41	COB
Supervisor, Utilization Management	OC-06	COB

Total: 221

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code, but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB
Chief Executive Officer	Files with	COB
Chief Financial Officer	Files with	COB
Member of the Board of Directors	Files with	COB

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

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Disclosure Descriptions
EXHIBIT B

Entity: **Other Misc. Authorities, Districts and Commissions**
Agency: **CalOptima**

Disclosure Category	Disclosure Description
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*..
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.

Disclosure Category	Disclosure Description
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.

Grand Total: 9

SUPPLEMENT TO FORM 700

CALOPTIMA

Please print:

Name: _____

The purpose of this disclosure form is to ensure that decisions are in the best interest of CalOptima and that no individual achieves personal gain because of his / her position with or without knowledge of CalOptima.

Please complete the following:

1. Are you or anyone in your family a director, officer, employee or owner in any business or entity (e.g., bank, real estate brokerage firm, consulting firm, construction company, insurance broker, architectural, law firm, medical group, etc.) which has done business in the past 12 months with CalOptima, or currently is or contemplates doing business with CalOptima in the next 12 months?_____(yes or no)

   Entity for these purposes includes any for profit, non-profit or public entity. *If yes, please disclose at end*

Please explain your relationship with such business or entity and the transaction with CalOptima.

_____

_____

_____

2. Are there any circumstances or other matters of a personal or family nature, direct or indirect, which could conflict with the interests of CalOptima?_____(yes or no) *If yes, please disclose at end.*

3. Disclose any other activities which you or anyone in your family are engaging in, or are considering engaging in, which may be deemed by CalOptima's management or Board to present a potential conflict of interest.

_____ _____

Signature Date

Please disclose any information here:

_____

_____

_____

_____

_____

(Please attach additional sheets if needed)

Human Resources *Approved:*

SUPPLEMENT TO FORM 700

CALOPTIMA

Please print:

Name: _____

The purpose of this disclosure form is to ensure that decisions are in the best interest of CalOptima and that no individual achieves personal gain because of his / her position with or without knowledge of CalOptima.

Please complete the following:

1. Are you or anyone in your family a director, officer, employee or owner in any business or entity (e.g., bank, real estate brokerage firm, consulting firm, construction company, insurance broker, architectural, law firm, medical group, etc.) which has done business in the past 12 months with CalOptima, or currently is or contemplates doing business with CalOptima in the next 12 months?_____(yes or no)

   Entity for these purposes includes any for profit, non-profit or public entity. *If yes, please disclose at end*

Please explain your relationship with such business or entity and the transaction with CalOptima.

_____

_____

_____

2. Are there any circumstances or other matters of a personal or family nature, direct or indirect, which could conflict with the interests of CalOptima?_____(yes or no) *If yes, please disclose at end.*

3. Disclose any other activities which you or anyone in your family are engaging in, or are considering engaging in, which may be deemed by CalOptima's management or Board to present a potential conflict of interest.

_____ _____

Signature Date

Please disclose any information here:

_____

_____

_____

_____

_____

(Please attach additional sheets if needed)

Human Resources *Approved:*

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Employee Report of Outside Interest and/or Other Employment

Employees are required to submit this form to Human Resources in the event of:

A) Any other job being held while employed with CalOptima, and/or;

B) Any outside interest(s) he/she may have which might be foreseeable or could be perceived as a potential conflict of interest with his/her employment with CalOptima.

It is understood that not all personal outside interest(s) which may interact with and/or relate to CalOptima employment constitute a conflict of interest. By reporting any such related outside interest(s), it is hoped that any potential conflict may be avoided.

Name_____ **Position** _____

Department_____ **Supervisor** _____

A) Other Job / Position:

Place of Employment _____

Location/Address _____

Hours/Schedule _____

B) **Outside Interest:** Describe the nature of your association/position in which you have an outside interest, which may have a real or perceived connection, influence or interaction with your employment/position at CalOptima:

Explain any actions/precautions that you will take to avoid any conflict of interest with your CalOptima employment:

I understand that it is my responsibility to ensure there are no conflicts of interest with my CalOptima employment:

Employee Name (please print):_____

Employee signature: _____ Date _____

Approved by:

Manager/Executive: _____ Date _____

Compliance: _____ Date _____

Human Resources: _____ Date _____

Legal (if necessary): _____ Date _____

This form must be typed. Signatures need to be in Blue or black ink.

Additional Comments:

Employee Report of Outside Interest and/or Other Employment

Employees are required to submit this form to Human Resources in the event of:

A) Any other job being held while employed with CalOptima, and/or;

B) Any outside interest(s) he/she may have which might be foreseeable or could be perceived as a potential conflict of interest with his/her employment with CalOptima.

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Name_____ **Position** _____

Department_____ **Supervisor** _____

A) Other Job / Position:

Place of Employment _____

Location/Address _____

Hours/Schedule _____

B) **Outside Interest:** Describe the nature of your association/position in which you have an outside interest, which may have a real or perceived connection, influence or interaction with your employment/position at CalOptima:

Explain any actions/precautions that you will take to avoid any conflict of interest with your CalOptima employment:

I understand that it is my responsibility to ensure there are no conflicts of interest with my CalOptima employment:

Employee Name (please print):_____

Employee signature: _____ Date _____

Approved by:

Manager/Executive: _____ Date _____

Compliance: _____ Date _____

Human Resources: _____ Date _____

Legal (if necessary): _____ Date _____

This form must be typed. Signatures need to be in blue or black ink.

Additional Comments:

Policy:	GA.8018
Title:	**Paid Time Off (PTO)**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	10/27/2011
Revised Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides managers and supervisors with appropriate guidelines to administer CalOptima's Paid Time Off (PTO) benefit.

II. POLICY

A. CalOptima provides PTO ~~benefits~~, a work-life balance benefit, to all eligible employees to enable them to take time off from work for activities such as rest ~~and~~, recreation ~~and to recover~~, recovery from injury and illness~~.~~ or other personal activities. CalOptima believes this time is valuable for employees in order to enhance productivity and ~~to~~ make the work experience more personally satisfying. CalOptima provides ~~long service~~ employees with additional hours of PTO ~~benefits~~ as years of service are accumulated.

B. Full-Time, Part-Time, and Limited Term Employees who are regularly scheduled to work more than twenty (20) hours per week are eligible to accrue PTO. An eligible employee may use PTO hours for vacation, preventative health, or dental care, or care of an existing health condition of the employee, or the employee's family member, short-term illness, family illness, emergencies, religious observances, personal business, Child-Related Activities, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. CalOptima encourages employees to maintain work-life balance by utilizing PTO benefits for rest and recreation throughout the year.

C. Healthy Workplaces, Healthy Families Act of 2014 ("Act"), effective July 1, 2015, requires CalOptima to provide paid sick leave to eligible employees. CalOptima already provides employees who are eligible to accrue PTO, as specified in Section III.B. above, a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover, and use requirements under the Act. For all other employees who are not eligible to accrue PTO as specified in Section II.B. above, such as As-Needed Employees, who work thirty (30~~),~~) or more~~,~~ days within one (1) year from the start of their date of employment, the following provisions shall apply:

1. CalOptima shall provide the full amount of twenty-four (24) hours~~,~~ or three (3) days, whichever is greater, of paid sick leave to eligible employees~~,~~ on July 1, 2015, and then at the beginning of each calendar year thereafter. For eligible employees hired, or engaged, after July 1, 2015, the full amount of twenty-four (24) hours, or three (3) days, whichever is greater, of paid sick leave

shall be provided beginning at the commencement of employment~~,~~ or engagement~~,~~ and then at the beginning of each calendar year thereafter. As such, the employee will not accrue any additional paid sick leave and will not carry over any unused sick leave hours to the following year.

2. Upon satisfying a ninety (90) day employment period, employees may use accrued sick leave for preventative care or diagnosis, and care or treatment of an existing health condition of the employee~~,~~ or the employee's family member. The Act defines a "family member" as a child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling. Eligible employees may also use accrued paid sick leave for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking.

3. Paid sick leave will not be treated the same as PTO. Upon termination, resignation, retirement, or other separation from employment, CalOptima will not payout employees for unused paid sick leave time accrued under the Act. In addition, accrued paid sick leave time is not eligible for cash out. If an employee separates and is then rehired by CalOptima within one (1) year from the date of separation, the previously accrued and unused paid sick leave time will be reinstated. An employee rehired within one (1) year from the date of separation may not be subject to the Act's ninety (90)-day waiting period, if such condition was previously satisfied, and may use their paid sick leave time immediately upon rehire, if eligible.

D. **PTO Accrual**: An eligible employee accrues PTO hours based on his or her classification as exempt~~,~~ or non-exempt, hours paid (excluding overtime) each pay period (non-exempt employees), and years of Continuous Service in accordance with the ~~following~~ accrual schedule ~~outlined~~provided below. PTO begins accruing from the date of hire. On rare occasions and on a case-by-case basis, the Chief Executive Officer may approve deviations ~~from the following accrual schedule of up to a maximum of ten (10) days accrued per year~~of up to a maximum of ten (10) days accrued per year from the accrual schedule below. In addition, the CEO may authorize one-time PTO of up to a maximum of eight (8) hours per employee per incident, in cases of local emergencies or unforeseen circumstances necessitating time off for the immediate protection, welfare and safety of the employee and/or CalOptima property.

Annual Paid Time Off Benefits Accrual Schedule

In the accrual tables below, the total hours accrued is based on the number of hours paid, prorated for employees who work less than a full-time schedule, and calculated up to a maximum of eighty (80) hours for the biweekly pay period.

Non-Exempt Employees:

Years of Continuous Service	Hours of PTO Accrued (Biweekly pay period)	Annual Hourly Accrual	Days Accrued per Year
0 – 3	5.54	144 ~~hrs~~	18
4 – 10	7.08	184 ~~hrs~~	23
11 +	8.62	224 ~~hrs~~	28

Exempt Employees:

Years of Continuous Service	Hours of PTO ~~Earned~~Accrued (Biweekly pay period)	Annual Hourly Accrual	Days Accrued per Year
0 – 3	7.08	184 ~~hrs~~	23

4 – 10	8.62	224 ~~hrs~~	28
11 +	10.15	264 ~~hrs~~	33

E. **Maximum Accrual:** Limits are imposed on the amount of PTO that can be maintained in an employee's PTO account. ~~In the event that~~If available PTO is not used by the end of the benefit year ~~([~~benefit year is the twelve (12) month period from hire date~~),~~], employees may carry unused time off into subsequent years, up to the maximum accrual amount specified herein. The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's Annual Accrual (see chart above). If an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO.

F. **PTO Accrual during Leaves of Absence:** PTO does not accrue when absent from work in connection with an approved or unapproved unpaid Leave of Absence, including, but not limited to, workers' compensation leave or short/long term disability. PTO accruals recommence when the employee returns to work from an unpaid Leave of Absence.

~~G. **PTO Increments**: At the manager's, or supervisor's, discretion, eligible employees may use time from their PTO account in increments of at least one-quarter (1/4) of an hour.~~

~~H.~~G. **PTO Scheduling**: Scheduling of PTO ~~time~~ is to be done in a manner compatible with CalOptima's operational requirements. In order to minimize the impact of an employee's absence, ~~PTO requests (vacations, medical appointments)~~planned time off should be submitted by an employee to his or her immediate supervisor for approval at least two (2) weeks before the requested time off. Advance approval by the supervisor is subject to the condition that the employee has sufficient time available in the employee's PTO account at the time the employee uses the PTO. Supervisors have authority to approve or deny PTO requests based on business needs, and CalOptima will not be responsible for any expenses incurred by an employee if the request for PTO is not approved. Each department may have special scheduling requirements and procedures for requesting PTO~~,~~; therefore, employees should check with ~~his or her~~their immediate supervisor in advance, except for purposes of sick leave. In rare cases, an Executive may authorize the rescission of approved PTO to address urgent, emergent, or emergency situations. Notification to the employee will be made as soon as the need is known.

~~I.~~H. **PTO for Leaves of Absence Pursuant to Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Other Leaves**: CalOptima is required to provide time off to eligible employees in accordance with applicable laws. Accrued PTO will automatically be used to pay employees for any period of time taken off under the FMLA, and/or the CFRA (for their own serious health condition, or that of an immediate family member, unless such health condition qualifies under the PDL~~.~~).Family member for the purposes of FMLA and CFRA includes a spouse, parent, or child, and ~~also~~ includes care for the birth, adoption, or foster care placement of a child, or other qualified next of kin. Use of PTO for any period of time taken off under PDL is at the discretion of the employee. Accrued PTO will also be automatically used towards paid sick leave for preventative care, or care of an existing health condition for the employee, or a family member, which includes the employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, or sibling, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. ~~Employees~~In addition, employees may use half of their annual accrued PTO for preventive care, or care of an existing health condition for the employee, or a family member as permitted under Labor Code, Sections 233 ~~(generally known as "Kin Care," but also referred to as "Protected Sick Leave") and 246.5(a).~~ . Accrued PTO shall also be automatically used for time-off for Child-Related Activities, subject to

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the limitations under Labor Code, Section 230.8. At the employee's discretion, PTO may also be used to supplement an employee's income, up to one hundred percent (100%), if an employee is receiving short/long term disability benefits during an approved unpaid Leave of Absence. Leave rights discussed herein may overlap and shall not create greater rights than permitted under applicable laws. For example, the right of an employee on a Leave of Absence for his or her own serious health condition under FMLA and CFRA may coincide with his or her rights under the Act and Protected Sick Leave, such that he or she shall only be entitled to the maximum amount of time off permitted under FMLA/CFRA, or Protected Sick Leave, whichever is greater. As another example, an employee who ~~exhausts~~has exhausted all of his or her accrued PTO ~~for vacation~~ shall not be entitled to additional paid leave under ~~the Act,~~either Acts or under Protected Sick Leave~~, if he or she becomes sick and does not have any accrued PTO available~~.

~~J.~~I. **Unscheduled PTO**: ~~Unscheduled absences, due to illness or emergencies, must be reported to the employee's manager and/or supervisor no later than the start~~Regardless of the ~~workday (unless the situation makes this impossible), along with an explanation~~reason for ~~the~~an unscheduled ~~time off.~~absence, an employee shall notify his/her immediate supervisor in accordance with CalOptima Policy GA.8059: Attendance and Timekeeping . Notification of an unscheduled absence does not make the absence authorized. An employee shall enter the PTO request into the timekeeping system as soon as reasonably possible, and the employee's PTO account will be deducted accordingly. Excessive use of unscheduled PTO above and beyond what is allowed under Protected Sick Leave may result in discipline, up to and including termination. If an employee is absent for four (4) consecutive days, or more, on personal and unprotected sick time, a doctor's note is required on the first day back.

~~K.~~J. **Holidays Occurring During PTO**: If an observed CalOptima holiday occurs during an employee's scheduled PTO, the employee's PTO account will not be deducted for that holiday day.

~~L.~~K. **Maximum Annual Cash Out**: An election period will be held each year at about the same time as CalOptima's annual open enrollment period~~, during which~~. During this time, each employee may elect, for the following year, to convert to cash PTO hours up to the full amount that the employee will be eligible to accrue at the time of cash out in the next calendar year. Once the election period closes, but in no event after December 31 of the year prior to payment of the cash out, the request for PTO cash out cannot be revoked. Requests for cash out will be paid out once per calendar year as determined by the Human Resources Department, provided that all of the following criteria are met: (1) ~~that~~ the employee made the election during the applicable open enrollment period, (2) ~~that~~ the employee has actually accrued the requested amount of hours in the same year and by the time the cash out is made, and (3) ~~that~~ a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. If the employee's election to cash out is for more hours than are eligible, the cash out will be limited to the number of eligible PTO hours at the time the cash out is made. Cashed out PTO will be paid at the employee's current hourly rate at the time the PTO cash out is scheduled to be paid, subject to all applicable taxes and deductions.

~~M.~~L. **Cash Out for Financial Hardship:** If~~,~~ during the year~~,~~ an employee experiences a personal financial hardship, the employee can cash out his or her accrued PTO hours. Cash out for financial hardships are limited to ~~help meet this need.~~ one per calendar year. Documentation ~~must be provided~~ verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need and there must be no other resources readily available to handle that financial need. Financial hardships shall be limited to the following reasons:

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1. Expenses for, or necessary, to obtain non-reimbursed medical care~~,~~ for employee or immediate family members;

2. Payment for the purchase of a primary residence;

3. Payment of tuition, related education fees, and room and board expenses for postsecondary education for the employee, or the employee's spouse~~,~~ (or registered domestic partner), children, or dependents;

4. Payments necessary to prevent the employee from eviction~~,~~ or foreclosure~~, to an employee's home~~;

5. Expenses for the repair of damage to an employee's ~~principal~~primary residence for damages from natural disasters; or

6. ~~Payments~~Expenses for the burial, ~~or~~ funeral, ~~expenses~~or memorial for an employee's deceased parent, spouse~~,~~ (or registered domestic partner), children, or dependents.

~~N.~~M. **PTO Pay/Flex Pay on Termination**: Employees are expected to give at least two (2) weeks' written notice prior to resigning from his or her employment. Notice of resignation is expected to be a "working" notice to allow an opportunity for productive work time to complete projects, or train whoever will be assuming the employee's responsibilities. For that reason, employees should avoid using accrued PTO during the two (2) week period preceding their last scheduled day of work and/or coordinate the use of PTO time to provide at least two (2) "working" weeks. In no event shall CalOptima permit an employee to use his or her accrued PTO beyond the last day worked by an employee, unless the employee was on an approved Leave of Absence, or unless otherwise required by law. Upon termination of employment, the employee is paid all accrued unused PTO and Flex Holiday time at the employee's base rate of pay, subject to all applicable taxes, at the time of the termination. According to California Labor Code, Section 220(b), as a public agency, CalOptima is not required to pay wages immediately upon termination. CalOptima will pay the employee on the next regularly scheduled pay day.

~~O.~~N. **PTO Donation Program**: At the discretion of the Human Resources Department, a PTO Donation Program may be implemented. Employees may donate accrued PTO hours to assist another CalOptima employee ("Recipient Employee") when a Recipient Employee qualifies as having a Catastrophic Illness. Donations are completely voluntary, and donors will remain anonymous to the Recipient Employee. ~~Employees wishing to donate accrued PTO hours ("Donor Employee") must surrender a minimum of two (2) hours, and thereafter, in one (1) hour increments, may surrender an unlimited number of PTO hours, to CalOptima for the benefit of an eligible Recipient Employee, as long as the Donor Employee maintains a minimum of one hundred (100) accrued PTO hours in the Donor Employee's PTO account after donation.~~

1. To be eligible to receive PTO donations, a Recipient Employee must meet all ~~of~~ the following criteria:

   a. Have a Catastrophic Illness, which shall mean a major illness~~,~~ or other medical condition (e.g., heart attack, cancer, etc.) ~~of the employee,~~ or have a family member ~~of the employee that~~with a Catastrophic Illness which requires the employee take a prolonged absence ~~of the employee from work,~~ including intermittent absences that are related to the same illness, or condition, and which will result in a substantial loss of income to the employee because the

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employee will have exhausted all PTO available apart from the PTO Donation Program. Family members referenced above shall include an employee's~~:~~ spouse (or registered domestic partner); biological, adopted, step, or foster, child under age eighteen (18), or an adult dependent child substantially limited by a physical, or mental, impairment; or biological, adopted, step, or foster, parent;

b. Have worked for CalOptima for at least ninety (90) days and be eligible to accrue PTO hours under this Policy;

c. Be in Good Standing (no written warnings~~,~~ or corrective action plans within the last six (6) months, and the most recent performance evaluation shows the employee is meeting the performance standards);

d. Exhausted all of his or her own PTO time;

e. Completed a written request and authorization form including medical documentation to be approved by the Human Resources Department;

f. Have the scheduled time off~~,~~ or Leave of Absence, approved by CalOptima in accordance with CalOptima's Leave of Absence and Personal Leave of Absence Policies; and

g. Have not resigned~~,~~ or been terminated~~,~~ from employment prior to or during the employee's time off~~,~~ or Leave of Absence.

2. To donate, a Donor Employee must meet all ~~of~~ the following criteria:

a. Donate and surrender a minimum of two (2) hours, in increments of one (1) hour.

b. Maintain a minimum balance of one hundred (100) accrued PTO hours in the Donor Employee's PTO account after donation.

c. Submit a form authorizing the donation and acknowledging that the donated PTO time has been surrendered to CalOptima for the benefit of another employee and is no longer a benefit to the Donor Employee.

3. PTO donation pay rate. PTO hours donated will be transferred to the Recipient Employee on an hour-for-hour basis at the Recipient Employee's rate of pay, without regard to the rate of pay of the Donor Employee. The Recipient Employee is responsible for the tax burden of the donation. Any donated PTO that is not used by the Recipient Employee shall remain in the Recipient Employee's PTO account for future use.

4. Disability or workers' compensation. If a Recipient Employee is receiving ~~Short Term/Long Term Disability~~short term or ~~worker's~~long term disability or workers' compensation benefits, the Recipient Employee may coordinate the donated PTO hours with these benefits to supplement the Recipient Employee's income up to one hundred percent (100%) of the employee's salary. For instance, if the Recipient Employee is receiving sixty percent (60%) of his or her income from ~~Short Term Disability~~short term disability, CalOptima will allow the Recipient Employee to use the donated PTO hours to supplement up to the forty percent (40%) difference in compensation, bringing the Recipient Employee's total monthly income to one hundred percent (100%) of his or her earnings.

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5. The Recipient Employee must submit an application and all necessary documentation to the Human Resources Department to be a recipient of the donated PTO and must give CalOptima permission to issue an all-staff email announcing the opportunity to donate PTO. The email will identify the Recipient Employee and any other information expressly authorized by the Recipient Employee.

6. In submitting an application, the Recipient Employee will be required to save, defend, and hold CalOptima harmless from any claims, liability, or actions concerning the disclosure of health information authorized by the Recipient Employee.

7. This PTO Donation program is completely voluntary on the part of CalOptima and may be amended~~,~~ or terminated~~,~~ by the Human Resources Department at any time ~~in~~at its sole discretion.

III. PROCEDURE

A. PTO or Paid Sick Leave Time Request for Time Off:

Responsible Party	Action
Employee	• Request PTO or paid sick leave at least two (2) weeks in advance, where possible, using CalOptima's time-keeping system. If the need for time off is foreseeable, employee must provide reasonable advance notice. If not, the employee must provide notice as soon as practicable. (If using PTO or paid sick leave for illness or preventative treatment, enter time away from work request as PTO Sick).
Supervisor	• Review all requests and approve, or deny, the request.

B. PTO Request to Cash Out:

Responsible Party	Action
Employee	• Request PTO cash out for the following year during the designated election period~~. Total hours cashed out must be actually accrued in the same calendar year as the year it is cashed out and by the time the cash out is made. Total hours remaining in PTO account must be a minimum of one hundred (100) hours after cash out.~~
Payroll	• Review all requests and approve~~,~~ or deny~~,~~ the request.

C. PTO Request for Donations (Recipient Employee):

Responsible Party	Action
Recipient Employee	• Request a Leave of Absence. • Complete a written request and authorization form including supporting medical documentation to be submitted ~~and approved by~~ to the Human Resources Department for approval, if eligible. • Sign a written waiver concerning disclosure of information to CalOptima employees.
Human Resources Department	• Receive request and authorization form from Recipient Employee and review for completeness and eligibility.

Responsible Party	Action
	• ~~Provide~~Within ten (10) days of receipt of all necessary material provide notice to ~~employee~~Recipient Employee whether or not Human Resources approves~~,~~ or rejects~~,~~ the employee's request ~~within ten (10) days of receipt of all necessary material.~~ • Where approved, send out email request to all CalOptima employees consistent with permissible information provided by the Recipient Employee.

D. PTO Request to Donate (Donor Employee):

Responsible Party	Action
Donor Employee	• Submit a form authorizing the donation and designating the number of hours surrendered to CalOptima for the benefit of a Recipient Employee. • Sign an acknowledgement that the donated PTO time has been surrendered to CalOptima for the benefit of a Recipient Employee and is no longer a benefit to the Donor Employee. • ~~Ensure that the Donor Employee has a minimum of one hundred (100) hours remaining in the Donor Employee's PTO account after donation.~~
Human Resources Department	• Receive donation form from Donor Employee and review for completeness and eligibility. • ~~Provide~~Within ten (10) days of receipt of all necessary material provide notice to Donor Employee whether or not Human Resources ~~approved,~~approves or ~~rejected,~~rejects the ~~Donor Employee's authorization for donation and surrender.~~ • employee's request Where approved, transfer the donated PTO hours to the Recipient Employee on an hour for hour basis at the Recipient Employee's rate of pay.

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IV. ATTACHMENT(S)

A. PTO Donation Program –Request and Authorization Form – Recipient Employee
B. PTO Donation Program –Donation and Authorization Form – Donor Employee
C. Cash Out PTO for Financial Hardship Request Form

V. REFERENCE(S)

A. California Labor Code, §§230.8, 233, and 246 *et seq*.
B. CalOptima Employee Handbook
~~C.~~ CalOptima Policy GA.~~8000: Glossary of Terms~~
~~D.~~C. ~~CalOptima Policy GA.~~8037: Leave of Absence
~~E.~~D. CalOptima Policy GA.8038: Personal Leave of Absence
~~F.~~E. CalOptima Policy GA.8040: FMLA and CFRA Leaves of Absence
~~G.~~F. CalOptima Policy GA.8041: ~~Worker's~~Workers' Compensation Leave of Absence
G. CalOptima Policy GA.8059: Attendance and Timekeeping

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTIONS

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/2011	GA.8018	Paid Time Off (PTO)	Administrative
Revised	03/26/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	05/01/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	08/07/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	06/04/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	02/02/2017	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2020	GA.8018	Paid Time Off (PTO)	Administrative

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IX. GLOSSARY

Term	Definition
As-Needed	Employees called to work sporadically on an as-needed basis. These employees may not have regularly scheduled hours and do not earn any benefits. As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.
Catastrophic Illness	A major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program.
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 Service	A period of employment with one (1) employer, which begins with the~~-~~ day on which the employee starts work and ends with the date of resignation or dismissal. All service, regardless of hours worked, counts toward calculating continuous service.
Exempt Employee	~~Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries, where applicable.~~ Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and ~~is defined by Human Resources for each position.~~ consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. Exempt employees do not earn overtime compensation.
Full-Time Employee	An employee who works sixty (60) to eighty (80) hours a pay period.
Good Standing	The employee has at least a ~~fully meets expectations job~~satisfactory level of performance ~~rating~~ on their most recent evaluation and has not received written ~~disciplinary~~corrective action within the last six (6) months.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off that an employee is to be away from his or her primary job, while maintaining the status of employee.
Limited Term Employee	Employees who are hired to work a full-time schedule on special-assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.
Non-Exempt Employee	~~Includes~~Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation ~~as required by~~. Although an employee's classification may qualify for applicable federal ~~wage and hour~~

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Term	Definition
	~~laws.~~ exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Paid Interns	Paid interns are considered As-Needed employees~~,~~ and should be concurrently enrolled in college or graduate courses.
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.

Policy:	GA.8018
Title:	**Paid Time Off (PTO)**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	10/27/2011
Revised Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides managers and supervisors with appropriate guidelines to administer CalOptima's Paid Time Off (PTO) benefit.

II. POLICY

A. CalOptima provides PTO, a work-life balance benefit, to all eligible employees to enable them to take time off from work for activities such as rest, recreation, recovery from injury and illness or other personal activities. CalOptima believes this time is valuable for employees in order to enhance productivity and make the work experience more personally satisfying. CalOptima provides employees with additional hours of PTO as years of service are accumulated.

B. Full-Time, Part-Time, and Limited Term Employees who are regularly scheduled to work more than twenty (20) hours per week are eligible to accrue PTO. An eligible employee may use PTO hours for vacation, preventative health, or dental care, or care of an existing health condition of the employee, or the employee's family member, short-term illness, family illness, emergencies, religious observances, personal business, Child-Related Activities, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. CalOptima encourages employees to maintain work-life balance by utilizing PTO benefits for rest and recreation throughout the year.

C. Healthy Workplaces, Healthy Families Act of 2014 ("Act"), effective July 1, 2015, requires CalOptima to provide paid sick leave to eligible employees. CalOptima already provides employees who are eligible to accrue PTO, as specified in Section III.B. above, a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover, and use requirements under the Act. For all other employees who are not eligible to accrue PTO as specified in Section II.B. above, such as As-Needed Employees, who work thirty (30) or more days within one (1) year from the start of their date of employment, the following provisions shall apply:

1. CalOptima shall provide the full amount of twenty-four (24) hours or three (3) days, whichever is greater, of paid sick leave to eligible employees on July 1, 2015, and then at the beginning of each calendar year thereafter. For eligible employees hired, or engaged, after July 1, 2015, the full amount of twenty-four (24) hours, or three (3) days, whichever is greater, of paid sick leave shall be provided beginning at the commencement of employment or engagement and then at

the beginning of each calendar year thereafter. As such, the employee will not accrue any additional paid sick leave and will not carry over any unused sick leave hours to the following year.

2. Upon satisfying a ninety (90) day employment period, employees may use accrued sick leave for preventative care or diagnosis, and care or treatment of an existing health condition of the employee or the employee's family member. The Act defines a "family member" as a child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling. Eligible employees may also use accrued paid sick leave for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking.

3. Paid sick leave will not be treated the same as PTO. Upon termination, resignation, retirement, or other separation from employment, CalOptima will not payout employees for unused paid sick leave time accrued under the Act. In addition, accrued paid sick leave time is not eligible for cash out. If an employee separates and is then rehired by CalOptima within one (1) year from the date of separation, the previously accrued and unused paid sick leave time will be reinstated. An employee rehired within one (1) year from the date of separation may not be subject to the Act's ninety (90)-day waiting period, if such condition was previously satisfied, and may use their paid sick leave time immediately upon rehire, if eligible.

D. **PTO Accrual**: An eligible employee accrues PTO hours based on his or her classification as exempt or non-exempt, hours paid (excluding overtime) each pay period (non-exempt employees), and years of Continuous Service in accordance with the accrual schedule provided below. PTO begins accruing from the date of hire. On rare occasions and on a case-by-case basis, the Chief Executive Officer may approve deviations of up to a maximum of ten (10) days accrued per year from the accrual schedule below. In addition, the CEO may authorize one-time PTO of up to a maximum of eight (8) hours per employee per incident, in cases of local emergencies or unforeseen circumstances necessitating time off for the immediate protection, welfare and safety of the employee and/or CalOptima property.

Annual Paid Time Off Benefits Accrual Schedule

In the accrual tables below, the total hours accrued is based on the number of hours paid, prorated for employees who work less than a full-time schedule, and calculated up to a maximum of eighty (80) hours for the biweekly pay period.

Non-Exempt Employees:

Years of Continuous Service	Hours of PTO Accrued (Biweekly pay period)	Annual Hourly Accrual	Days Accrued per Year
0 – 3	5.54	144	18
4 – 10	7.08	184	23
11 +	8.62	224	28

Exempt Employees:

Years of Continuous Service	Hours of PTO Accrued (Biweekly pay period)	Annual Hourly Accrual	Days Accrued per Year
0 – 3	7.08	184	23
4 – 10	8.62	224	28
11 +	10.15	264	33

E. **Maximum Accrual:** Limits are imposed on the amount of PTO that can be maintained in an employee's PTO account. If available PTO is not used by the end of the benefit year [benefit year is the twelve (12) month period from hire date], employees may carry unused time off into subsequent years, up to the maximum accrual amount specified herein. The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's Annual Accrual (see chart above). If an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO.

F. **PTO Accrual during Leaves of Absence:** PTO does not accrue when absent from work in connection with an approved or unapproved unpaid Leave of Absence, including, but not limited to, workers' compensation leave or short/long term disability. PTO accruals recommence when the employee returns to work from an unpaid Leave of Absence.

G. **PTO Scheduling**: Scheduling of PTO is to be done in a manner compatible with CalOptima's operational requirements. In order to minimize the impact of an employee's absence, planned time off should be submitted by an employee to his or her immediate supervisor for approval at least two (2) weeks before the requested time off. Advance approval by the supervisor is subject to the condition that the employee has sufficient time available in the employee's PTO account at the time the employee uses the PTO. Supervisors have authority to approve or deny PTO requests based on business needs, and CalOptima will not be responsible for any expenses incurred by an employee if the request for PTO is not approved. Each department may have special scheduling requirements and procedures for requesting PTO; therefore, employees should check with their immediate supervisor in advance, except for purposes of sick leave. In rare cases, an Executive may authorize the rescission of approved PTO to address urgent, emergent, or emergency situations. Notification to the employee will be made as soon as the need is known.

H. **PTO for Leaves of Absence Pursuant to Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Other Leaves**: CalOptima is required to provide time off to eligible employees in accordance with applicable laws. Accrued PTO will automatically be used to pay employees for any period of time taken off under the FMLA, and/or the CFRA (for their own serious health condition, or that of an immediate family member, unless such health condition qualifies under the PDL).Family member for the purposes of FMLA and CFRA includes a spouse, parent, or child, and includes care for the birth, adoption, or foster care placement of a child, or other qualified next of kin. Use of PTO for any period of time taken off under PDL is at the discretion of the employee. Accrued PTO will also be automatically used towards paid sick leave for preventative care, or care of an existing health condition for the employee, or a family member, which includes the employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, or sibling, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. In addition, employees may use half of their annual accrued PTO for preventive care, or care of an existing health condition for the employee, or a family member as permitted under Labor Code, Sections 233. Accrued PTO shall also be automatically used for time-off for Child-Related Activities, subject to the limitations under Labor Code, Section 230.8. At the employee's discretion, PTO may also be used to supplement an employee's income, up to one hundred percent (100%), if an employee is receiving short/long term disability benefits during an approved unpaid Leave of Absence. Leave rights discussed herein may overlap and shall not create greater rights than permitted under applicable laws. For example, the right of an employee on a Leave of Absence for his or her own serious health condition under FMLA and CFRA may coincide with his or her rights under the Act and Protected Sick Leave, such that he or she shall only be entitled to the maximum amount of time off permitted under FMLA/CFRA, or Protected Sick Leave, whichever is greater. As another example,

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an employee who has exhausted all of his or her accrued PTO shall not be entitled to additional paid leave under either Acts or under Protected Sick Leave.

I. **Unscheduled PTO**: Regardless of the reason for an unscheduled absence, an employee shall notify his/her immediate supervisor in accordance with CalOptima Policy GA.8059: Attendance and Timekeeping . Notification of an unscheduled absence does not make the absence authorized. An employee shall enter the PTO request into the timekeeping system as soon as reasonably possible, and the employee's PTO account will be deducted accordingly. Excessive use of unscheduled PTO above and beyond what is allowed under Protected Sick Leave may result in discipline, up to and including termination. If an employee is absent for four (4) consecutive days, or more, on personal and unprotected sick time, a doctor's note is required on the first day back.

J. **Holidays Occurring During PTO**: If an observed CalOptima holiday occurs during an employee's scheduled PTO, the employee's PTO account will not be deducted for that holiday day.

K. **Maximum Annual Cash Out**: An election period will be held each year at about the same time as CalOptima's annual open enrollment period. During this time, each employee may elect, for the following year, to convert to cash PTO hours up to the full amount that the employee will be eligible to accrue at the time of cash out in the next calendar year. Once the election period closes, but in no event after December 31 of the year prior to payment of the cash out, the request for PTO cash out cannot be revoked. Requests for cash out will be paid out once per calendar year as determined by the Human Resources Department, provided that all of the following criteria are met: (1) the employee made the election during the applicable open enrollment period, (2) the employee has actually accrued the requested amount of hours in the same year and by the time the cash out is made, and (3) a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. If the employee's election to cash out is for more hours than are eligible, the cash out will be limited to the number of eligible PTO hours at the time the cash out is made. Cashed out PTO will be paid at the employee's current hourly rate at the time the PTO cash out is scheduled to be paid, subject to all applicable taxes and deductions.

L. **Cash Out for Financial Hardship:** If during the year an employee experiences a personal financial hardship, the employee can cash out his or her accrued PTO hours. Cash out for financial hardships are limited to one per calendar year. Documentation verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need and there must be no other resources readily available to handle that financial need. Financial hardships shall be limited to the following reasons:

1. Expenses for, or necessary, to obtain non-reimbursed medical care for employee or immediate family members;

2. Payment for the purchase of a primary residence;

3. Payment of tuition, related education fees, and room and board expenses for postsecondary education for the employee, or the employee's spouse (or registered domestic partner), children, or dependents;

4. Payments necessary to prevent the employee from eviction or foreclosure;

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5. Expenses for the repair of damage to an employee's primary residence for damages from natural disasters; or

6. Expenses for the burial, funeral, or memorial for an employee's deceased parent, spouse (or registered domestic partner), children, or dependents.

M. **PTO Pay/Flex Pay on Termination**: Employees are expected to give at least two (2) weeks' written notice prior to resigning from his or her employment. Notice of resignation is expected to be a "working" notice to allow an opportunity for productive work time to complete projects, or train whoever will be assuming the employee's responsibilities. For that reason, employees should avoid using accrued PTO during the two (2) week period preceding their last scheduled day of work and/or coordinate the use of PTO time to provide at least two (2) "working" weeks. In no event shall CalOptima permit an employee to use his or her accrued PTO beyond the last day worked by an employee, unless the employee was on an approved Leave of Absence, or unless otherwise required by law. Upon termination of employment, the employee is paid all accrued unused PTO and Flex Holiday time at the employee's base rate of pay, subject to all applicable taxes, at the time of the termination. According to California Labor Code, Section 220(b), as a public agency, CalOptima is not required to pay wages immediately upon termination. CalOptima will pay the employee on the next regularly scheduled pay day.

N. **PTO Donation Program**: At the discretion of the Human Resources Department, a PTO Donation Program may be implemented. Employees may donate accrued PTO hours to assist another CalOptima employee ("Recipient Employee") when a Recipient Employee qualifies as having a Catastrophic Illness. Donations are completely voluntary, and donors will remain anonymous to the Recipient Employee.

1. To be eligible to receive PTO donations, a Recipient Employee must meet all the following criteria:

   a. Have a Catastrophic Illness, which shall mean a major illness or other medical condition (e.g., heart attack, cancer, etc.) or have a family member with a Catastrophic Illness which requires the employee take a prolonged absence including intermittent absences that are related to the same illness, or condition, and which will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program. Family members referenced above shall include an employee's spouse (or registered domestic partner); biological, adopted, step, or foster, child under age eighteen (18), or an adult dependent child substantially limited by a physical, or mental, impairment; or biological, adopted, step, or foster, parent;

   b. Have worked for CalOptima for at least ninety (90) days and be eligible to accrue PTO hours under this Policy;

   c. Be in Good Standing (no written warnings or corrective action plans within the last six (6) months, and the most recent performance evaluation shows the employee is meeting the performance standards);

   d. Exhausted all of his or her own PTO time;

   e. Completed a written request and authorization form including medical documentation to be approved by the Human Resources Department;

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f. Have the scheduled time off or Leave of Absence, approved by CalOptima in accordance with CalOptima's Leave of Absence and Personal Leave of Absence Policies; and

g. Have not resigned or been terminated from employment prior to or during the employee's time off or Leave of Absence.

2. To donate, a Donor Employee must meet all the following criteria:

a. Donate and surrender a minimum of two (2) hours, in increments of one (1) hour.

b. Maintain a minimum balance of one hundred (100) accrued PTO hours in the Donor Employee's PTO account after donation.

c. Submit a form authorizing the donation and acknowledging that the donated PTO time has been surrendered to CalOptima for the benefit of another employee and is no longer a benefit to the Donor Employee.

3. PTO donation pay rate. PTO hours donated will be transferred to the Recipient Employee on an hour-for-hour basis at the Recipient Employee's rate of pay, without regard to the rate of pay of the Donor Employee. The Recipient Employee is responsible for the tax burden of the donation. Any donated PTO that is not used by the Recipient Employee shall remain in the Recipient Employee's PTO account for future use.

4. Disability or workers' compensation. If a Recipient Employee is receiving short term or long term disability or workers' compensation benefits, the Recipient Employee may coordinate the donated PTO hours with these benefits to supplement the Recipient Employee's income up to one hundred percent (100%) of the employee's salary. For instance, if the Recipient Employee is receiving sixty percent (60%) of his or her income from short term disability, CalOptima will allow the Recipient Employee to use the donated PTO hours to supplement up to the forty percent (40%) difference in compensation, bringing the Recipient Employee's total monthly income to one hundred percent (100%) of his or her earnings.

5. The Recipient Employee must submit an application and all necessary documentation to the Human Resources Department to be a recipient of the donated PTO and must give CalOptima permission to issue an all-staff email announcing the opportunity to donate PTO. The email will identify the Recipient Employee and any other information expressly authorized by the Recipient Employee.

6. In submitting an application, the Recipient Employee will be required to save, defend, and hold CalOptima harmless from any claims, liability, or actions concerning the disclosure of health information authorized by the Recipient Employee.

7. This PTO Donation program is completely voluntary on the part of CalOptima and may be amended or terminated by the Human Resources Department at any time at its sole discretion.

III. PROCEDURE

A. PTO or Paid Sick Leave Time Request for Time Off:

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Responsible Party	Action
Employee	• Request PTO or paid sick leave at least two (2) weeks in advance, where possible, using CalOptima's time-keeping system. If the need for time off is foreseeable, employee must provide reasonable advance notice. If not, the employee must provide notice as soon as practicable. (If using PTO or paid sick leave for illness or preventative treatment, enter time away from work request as PTO Sick).
Supervisor	• Review all requests and approve, or deny, the request.

B. PTO Request to Cash Out:

Responsible Party	Action
Employee	• Request PTO cash out for the following year during the designated election period
Payroll	• Review all requests and approve or deny the request.

C. PTO Request for Donations (Recipient Employee):

Responsible Party	Action
Recipient Employee	• Request a Leave of Absence. • Complete a written request and authorization form including supporting medical documentation to be submitted to the Human Resources Department for approval, if eligible. • Sign a written waiver concerning disclosure of information to CalOptima employees.
Human Resources Department	• Receive request and authorization form from Recipient Employee and review for completeness and eligibility. • Within ten (10) days of receipt of all necessary material provide notice to Recipient Employee whether or not Human Resources approves or rejects the employee's request Where approved, send out email request to all CalOptima employees consistent with permissible information provided by the Recipient Employee.

D. PTO Request to Donate (Donor Employee):

Responsible Party	Action
Donor Employee	• Submit a form authorizing the donation and designating the number of hours surrendered to CalOptima for the benefit of a Recipient Employee. • Sign an acknowledgement that the donated PTO time has been surrendered to CalOptima for the benefit of a Recipient Employee and is no longer a benefit to the Donor Employee.
Human Resources Department	• Receive donation form from Donor Employee and review for completeness and eligibility. • Within ten (10) days of receipt of all necessary material provide notice to Donor Employee whether or not Human Resources approves or rejects the employee's request Where approved, transfer the donated PTO hours to the Recipient Employee on an hour for hour basis at the Recipient Employee's rate of pay.

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IV. ATTACHMENT(S)

A. PTO Donation Program –Request and Authorization Form – Recipient Employee
B. PTO Donation Program –Donation and Authorization Form – Donor Employee
C. Cash Out PTO for Financial Hardship Request Form

V. REFERENCE(S)

A. California Labor Code, §§230.8, 233, and 246 *et seq*.
B. CalOptima Employee Handbook
C. CalOptima Policy GA.8037: Leave of Absence
D. CalOptima Policy GA.8038: Personal Leave of Absence
E. CalOptima Policy GA.8040: FMLA and CFRA Leaves of Absence
F. CalOptima Policy GA.8041: Workers' Compensation Leave of Absence
G. CalOptima Policy GA.8059: Attendance and Timekeeping

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTIONS

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/2011	GA.8018	Paid Time Off (PTO)	Administrative
Revised	03/26/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	05/01/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	08/07/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	06/04/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	02/02/2017	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2020	GA.8018	Paid Time Off (PTO)	Administrative

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
As-Needed	Employees called to work sporadically on an as-needed basis. These employees may not have regularly scheduled hours and do not earn any benefits. As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.
Catastrophic Illness	A major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program.
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 Service	A period of employment with one (1) employer, which begins with the day on which the employee starts work and ends with the date of resignation or dismissal. All service, regardless of hours worked, counts toward calculating continuous service.
Exempt Employee	Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. Exempt employees do not earn overtime compensation.
Full-Time Employee	An employee who works sixty (60) to eighty (80) hours a pay period.
Good Standing	The employee has at least a satisfactory level of performance on their most recent evaluation and has not received written corrective action within the last six (6) months.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off that an employee is to be away from his or her primary job, while maintaining the status of employee.
Limited Term Employee	Employees who are hired to work a full-time schedule on special-assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Paid Interns	Paid interns are considered As-Needed employees and should be concurrently enrolled in college or graduate courses.

Back to Agenda Back to Item

Term	Definition
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.

1

PTO DONATION PROGRAM
REQUEST AND AUTHORIZATION FORM
CATASTROPHIC LEAVE REQUEST
Confidential

RECIPIENT EMPLOYEE

CalOptima has established a PTO Donation Program under HR Policy GA.8018: Paid Time Off ~~Policy~~ which allows employees to donate portions of their accrued PTO time to CalOptima for the benefit of an eligible requesting employee that has a catastrophic illness or has a family member with a Catastrophic Illness. Hours donated will be surrendered to CalOptima for the benefit of an eligible recipient employee on an hour for hour basis at the recipient's rate of pay, without regard for the rate of pay of the donor.

Name of Recipient Employee (Print):	**Employee ID #:**	**Date of Request:**
Email:	**Telephone:**	
Recipient Employee Job Title:	**Department:**	
Date Catastrophic Illness Began:	**Date Catastrophic Illness Ended/Expected to End:**	

I,_____ (print Recipient Employee name), hereby request PTO hour donations due to:

☐ my catastrophic illness
☐ my family member's catastrophic illness

Ddescribe medical condition: _____.

I have read HR Policy GA.8018, understand its contents, agree to the policies and procedures set forth therein, and hereby certify under penalty of perjury to all of the following:

☐	I personally, or a family member, have a catastrophic illness, and am submitting medical verification ~~am~~ confirming the catastrophic illness as defined in HR Policy GA.8018.
☐	I have worked for CalOptima for at least 90 days and am eligible to accrue PTO hours.
☐	I am in good standing.
☐	I have or will have exhausted all of my own PTO time.
☐	I have the scheduled time off or leave of absence approved by CalOptima.
☐	Have not resigned or been terminated from employment.

It ~~is~~ anticipated that I will have accrued PTO and/or Flex Holiday Time to cover my absence through _____. It is anticipated that I will receive Short Term Disability and/or Long-Term Disability or Workers' Compensation benefits through_____. To ☐ supplement these benefits ☐ cover the balance of the expected absence beyond that time, I am Requesting/Authorizing donations of PTO time from CalOptima which may be surrendered by Co-workers from their accrued PTO account. I understand the PTO available for my use under this Program is limited to the number of hours surrendered to CalOptima by other employees, that I will be paid only that amount of PTO necessary to obtain 100% of my salary, and that I will receive the PTO as part of the normal payroll cycle.

I understand that my request will be distributed to all CalOptima employees and that the request will identify me by name along with the following authorized disclosure concerning the nature of my request:
_____(information authorized by employee).

By submitting this form and signing below, I hereby agree to save, defend, indemnify and hold harmless CalOptima (including its Board, officers, employees, and agents) from any claims, liabilities or actions concerning the disclosure of my information related to this Request and Authorization for PTO donations.

Signed _____Date _____

***If not signed by employee, authorized representative must provide Power of Attorney or other documentation of legal authorization.**

RETURN COMPLETED FORM TO HUMAN RESOURCES

~~*FOR HR INTERNAL USE* (circle) Employee Eligible? YES NO Request Approved? YES NO~~

PTO DONATION PROGRAM
REQUEST AND AUTHORIZATION FORM
CATASTROPHIC LEAVE REQUEST
Confidential
RECIPIENT EMPLOYEE

CalOptima has established a PTO Donation Program under HR Policy GA.8018: Paid Time Off which allows employees to donate portions of their accrued PTO time to CalOptima for the benefit of an eligible requesting employee that has a catastrophic illness or has a family member with a Catastrophic Illness. Hours donated will be surrendered to CalOptima for the benefit of an eligible recipient employee on an hour for hour basis at the recipient's rate of pay, without regard for the rate of pay of the donor.

Name of Recipient Employee (Print):	**Employee ID #:**	**Date of Request:**
Email:	**Telephone:**	
Recipient Employee Job Title:	**Department:**	
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☐	I personally, or a family member, have a catastrophic illness, and am submitting medical verification confirming the catastrophic illness as defined in HR Policy GA.8018.
☐	I have worked for CalOptima for at least 90 days and am eligible to accrue PTO hours.
☐	I am in good standing.
☐	I have or will have exhausted all of my own PTO time.
☐	I have the scheduled time off or leave of absence approved by CalOptima.
☐	Have not resigned or been terminated from employment.

It is anticipated that I will have accrued PTO and/or Flex Holiday Time to cover my absence through _____. It is anticipated that I will receive Short Term Disability and/or Long-Term Disability or Workers' Compensation benefits through_____. To ☐ supplement these benefits ☐ cover the balance of the expected absence beyond that time, I am Requesting/Authorizing donations of PTO time from CalOptima which may be surrendered by Co-workers from their accrued PTO account. I understand the PTO available for my use under this Program is limited to the number of hours surrendered to CalOptima by other employees, that I will be paid only that amount of PTO necessary to obtain 100% of my salary, and that I will receive the PTO as part of the normal payroll cycle.

I understand that my request will be distributed to all CalOptima employees and that the request will identify me by name along with the following authorized disclosure concerning the nature of my request:

_____(information authorized by employee).

By submitting this form and signing below, I hereby agree to save, defend, indemnify and hold harmless CalOptima (including its Board, officers, employees, and agents) from any claims, liabilities or actions concerning the disclosure of my information related to this Request and Authorization for PTO donations.

Signed _____Date _____

***If not signed by employee, authorized representative must provide Power of Attorney or other documentation of legal authorization.**

RETURN COMPLETED FORM TO HUMAN RESOURCES

PTO DONATION PROGRAM
DONATION AND AUTHORIZATION FORM

CATASTROPHIC LEAVE DONATION

Confidential

DONATION OF PTO AUTHORIZATION TO BE GIVEN TO CO-WORKER

CalOptima has established a ~~P~~plan under HR Policy GA.-8018: Paid Time Off to allow for employees to donate from their PTO accruals to a requesting employee that has a ~~c~~catastrophic ~~i~~illness or has a family member with a c~~C~~atastrophic ~~i~~Illness. Catastrophic illness is~~,~~ defined as a major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program~~which means they have a serious medical condition that will disable them from work for an extended period of time that will exhaust their PTO~~ and Flex Holiday balance.

PTO hours donated will be transferred over on an hour for hour basis to be received as PTO pay at the recipient's rate of pay without regard to the rate of pay of the donor.

~~*Donors must give only with a minimum*~~ *PTO hours may be donated~~ion~~ to a recipient employee who has a catastrophic illness or has a family member with a catastrophic illness with a minimum donation of two (2) hours to a maximum of eight (8) hours per recipient within a ~~and/or per~~ three (3) month period of time. ~~for an individual recipient.~~*

To be completed by donating employee.

I, _____ (Name of Donating Employee) am hereby authorizing and voluntarily requesting that _____ hours (not less than 2, not more than 8) of my PTO hours be ~~deleted~~ removed from my accrued balance and transferred to the PTO balance of the recipient employee identified below as of the first day of the current pay period.

Name of Recipient Employee: _____

I understand that ~~this~~the hours I donate will no longer be a benefit to which I am entitled and that all rights to this time off will be transferred and paid to the recipient employee.

Signed _____ **Date** _____

Thank you for participating in this opportunity to help a Coworker in need. Names and amount of time donated will be kept confidential.

RETURN FORM CONFIDENTIALLY TO HUMAN RESOURCES

Donor Employee

CalOptima has established a PTO Donation Program under HR Policy GA. 8018: PTO Policy which allows employees to donate portions of their accrued PTO time to CalOptima for the benefit of an eligible requesting employee that has a catastrophic illness. Hours donated will be surrendered to CalOptima for the benefit of an eligible recipient employee on an hour for hour basis at the recipient's rate of pay, without regard for the rate of pay of the donor.

Name of Donor Employee (Print):	Donor Employee ID #:	Date of Donation:
Email:	Telephone:	
Recipient Employee Name & Department:	Number of Hours in Donor Employee PTO account:	

I wish to donate and surrender _____ (list number of hours, minimum of 2 hours must be donated) of my accrued PTO to CalOptima for the benefit of the above identified Recipient Employee.

I have read HR Policy GA. 8018, understand its contents, agree to the policies and procedures set forth therein, and hereby certify to the following:

☐ I will have a minimum balance of 100 accrued PTO hours in my PTO account after donation.

By submitting this form and signing below, I hereby understand and agree that this is a voluntary donation, that the above PTO hours will be surrendered to CalOptima for the benefit of the Recipient Employee that I have designated, if approved, and that these hours will no longer be a benefit to which I am entitled. If approved by HR, all rights to this time off will be surrendered to CalOptima, and will be transferred and paid to the Recipient Employee identified above at the Recipient Employee's rate of pay. I acknowledge and understand that the hours I surrender to CalOptima for the benefit of the Recipient Employee will not be transferred back to me if the Recipient Employee does not use all of them during his/her leave period and will become a part of the Recipient Employee's PTO account for use as the Recipient Employee chooses in accordance with the HR Policy GA. 8018: PTO Policy. I also understand that my donation will be anonymous.

Donor Employee Signature: _____ Date ___

RETURN COMPLETED FORM TO HUMAN RESOURCES

FOR HR INTERNAL USE (circle) Employee Eligible?

YES

NO

Request Approved? YES

NOHuman Resources

2019

PTO DONATION PROGRAM
DONATION AND AUTHORIZATION FORM
CATASTROPHIC LEAVE DONATION
Confidential

DONATION OF PTO AUTHORIZATION
TO BE GIVEN TO CO-WORKER

CalOptima has established a plan under HR Policy GA.8018: Paid Time Off to allow for employees to donate from their PTO accruals to a requesting employee that has a catastrophic illness or has a family member with a catastrophic illness. Catastrophic illness is defined as a major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program and Flex Holiday balance.

PTO hours donated will be transferred over on an hour for hour basis to be received as PTO pay at the recipient's rate of pay without regard to the rate of pay of the donor.

PTO hours may be donated to a recipient employee who has a catastrophic illness or has a family member with a catastrophic illness with a minimum donation of two (2) hours to a maximum of eight (8) hours per recipient within a three (3)-month period of time.

To be completed by donating employee.

I, _____ (Name of Donating Employee) am hereby authorizing and voluntarily requesting that _____ hours (not less than 2, not more than 8) of my PTO hours be removed from my accrued balance and transferred to the PTO balance of the recipient employee identified below as of the first day of the current pay period.

Name of Recipient Employee: _____

I understand that the hours I donate will no longer be a benefit to which I am entitled and that all rights to this time off will be transferred and paid to the recipient employee.

Signed _____ **Date** _____

Thank you for participating in this opportunity to help a Coworker in need. Names and amount of time donated will be kept confidential.

RETURN FORM CONFIDENTIALLY TO HUMAN RESOURCES

PTO DONATION PROGRAM

CASH OUT PTO FOR FINANCIAL HARDSHIP

REQUEST FORM

Confidential

CalOptima has established a PTO cash out for financial hardship option under HR Policy GA. 8018: Paid Time Off. This allows an employee who experiences a personal financial hardship, to cash out accrued PTO hours. A cash out for financial hardship requires documentation verifying the financial hardship and is subject to limitations. Examples of documentation are bank statements, "Past Due" invoices, and eviction notices.

To be completed by requesting employee.

EMPLOYEE NAME: _____

TOTAL HOURS REQUESTED: _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

APPROVED BY: _____ **DATE:** _____

RETURN FORM TO HUMAN RESOURCES

FOR OFFICE USE ONLY:

Remaining PTO Balance: _____ Date: _____

Total Time Approved: _____ Date: _____

In accordance with CalOptima Policy GA. 8018: Paid Time Off

If during the year an employee experiences a personal financial hardship, the employee can cash out his or her accrued PTO hours. Cash out for financial hardships are limited to one per calendar year. Documentation verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need.

Policy:	GA.8019
Title:	**Promotions and Transfers**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	12/03/2020

Applicable to:

- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

I. PURPOSE

This policy establishes a consistent method of considering current employees for internal promotions and transfers.

II. POLICY

A. CalOptima supports the development and advancement of its employees from within the organization.

B. CalOptima encourages employees to apply for promotions or transfers to open positions for which they meet the qualifications and minimum requirements.

C. CalOptima will normally post open positions internally for five (5) business days, allowing current employees who possess the necessary education, skills, and experience for the job position and who are in good standing to apply for the open positions.

D. To express interest in an open position, current employees must complete and submit an internal job application and attach an updated resume. An employee may also attach a cover letter.

E. An employee may be considered for an internal promotion, or transfer, only if the following conditions are met:

1. The employee's work performance is in good standing with a minimum of "Fully Meets Expectations" for the most current review period.

2. The employee must meet the qualifications and minimum requirements required for the position to which the transfer, or promotion, is sought.

3. The employee is not on a formal Performance Improvement Plan and/or has not received a Performance Improvement Plan, or a written, or final, warning within the last six (6) months.

4. The employee has been employed in his or her current position for a minimum of six (6) months.

a. Qualified internal applicants will be considered using the same process followed with external candidates, including interview questions, bilingual screening, and other skills tests, as appropriate.

F. On rare occasions, there may be situations where: (1) a position is not posted~~,~~; or (2) a transfer~~,~~ or promotion~~,~~ is granted due to a sensitive business need, ~~or where~~ necessitated by other requirements~~.~~, or implemented prior to the employee being in the position for six (6) months. Exceptions to the standard recruitment process may only be made if there is: (1) a substantiated and documented need to transfer or promote an employee; and (2) sufficient facts to establish that if CalOptima followed the standard procedure, it would result in a demonstrated impairment to the organization or a specific time sensitive project. Without such substantiated business need, the exception should not be made. The Chief Executive Officer (CEO) must approve ~~these exceptions~~the exception.

G. If a job offer is extended and accepted by a current employee, subject to the background check and/or any other required medical examinations, if applicable, the start date and transition to the new position will be coordinated between the employee, the new supervisor, and the current supervisor. The employee may need to be available to orient and train a replacement.

III. PROCEDURE

Responsible Party	Action
Employee	1. The employee is responsible for reviewing the job description and/or job posting and ensuring that he or she meets the qualifications and minimum requirements for the job before submitting an application. 2. In order to express interest in an open position, employees are responsible for taking ownership of their own career by completing an internal job application, attaching an updated resume, and submitting the complete package to the Human Resources (HR) Department. 3. Employees participate in the same process followed with external candidates, including an interview, bilingual screening, if applicable, and other skills tests applicable to the selection process.
Hiring Manager	1. Review internal job application with updated resume and notify HR to schedule an interview if the applicant is qualified. 2. Interview the internal applicant. 3. Once a qualified internal applicant has been identified and the Hiring Manager is interested in selecting that applicant to fill an open position, the Hiring Manager shall speak to internal applicant's immediate supervisor as a reference, and review the internal applicant's personnel files for past and current performance reviews with HR. 4. Discuss salary offer with HR. 5. The Hiring Manager will work with the selected employee's current manager to establish a fair start date for both departments.

-HR	1. Review internal applicant resumes. 2. Review personnel files for rating of employee for the most current review period and verify if the employee received a Performance Improvement Plan, or a written or final warning within the last six (6) months. 3. If internal applicant appears to meet qualifications and minimum requirements, HR will send the application to Hiring Manager. At the request of the Hiring Manager, HR shall schedule an interview with the internal applicant. If appropriate, the Hiring Manager will conduct a second interview with additional staff members. If the internal applicant is not selected, HR will notify internal applicant of the decision. 4. If an internal applicant is selected to fill an open position, HR will extend an offer, in consultation with the Hiring Manager, based on the employee's experience and skill level, current pay, classification of the open position, and CalOptima's Compensation Program and Salary Schedule. 5. HR will process an Action Form, which is an internal document used by HR in a form similar to the sample form attached hereto and which may be updated from time to time.

IV. ATTACHMENT(S)

A. Action Form (Sample)

V. REFERENCE(S)

A. CalOptima Employee Handbook

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
01/05/2012	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8019	Promotions and Transfers	Administrative
Revised	08/07/2014	GA.8019	Promotions and Transfers	Administrative
Revised	12/01/2016	GA.8019	Promotions and Transfers	Administrative
Revised	12/03/2020	GA.8019	Promotions and Transfers	Administrative

IX. GLOSSARY

Term	Definition
Hiring Manager	Person responsible for making final hiring decision.
Performance Improvement Plan	A developmental coaching tool used to ~~improve employee behavior and/or to address~~document performance and behavioral deficiencies ~~identified in the annual~~ or issues and create an action plan with goals and due dates to help employees correct and/or improve performance ~~review. The plan includes measurable expectations and accountability meetings.~~ and behavior while still holding them accountable for past performance.
Promotion	Occurs when a current employee advances to an open position at a higher classification and salary range from the employee's previous position.
Transfer	Occurs when an employee moves into a new position that is equivalent in its classification and salary range to the employee's previous position.

Policy:	GA.8019
Title:	**Promotions and Transfers**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	12/03/2020

Applicable to:

- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

I. PURPOSE

This policy establishes a consistent method of considering current employees for internal promotions and transfers.

II. POLICY

A. CalOptima supports the development and advancement of its employees from within the organization.

B. CalOptima encourages employees to apply for promotions or transfers to open positions for which they meet the qualifications and minimum requirements.

C. CalOptima will normally post open positions internally for five (5) business days, allowing current employees who possess the necessary education, skills, and experience for the job position and who are in good standing to apply for the open positions.

D. To express interest in an open position, current employees must complete and submit an internal job application and attach an updated resume. An employee may also attach a cover letter.

E. An employee may be considered for an internal promotion, or transfer, only if the following conditions are met:

1. The employee's work performance is in good standing with a minimum of "Fully Meets Expectations" for the most current review period.

2. The employee must meet the qualifications and minimum requirements required for the position to which the transfer, or promotion, is sought.

3. The employee is not on a formal Performance Improvement Plan and/or has not received a Performance Improvement Plan, or a written, or final, warning within the last six (6) months.

4. The employee has been employed in his or her current position for a minimum of six (6) months.

a. Qualified internal applicants will be considered using the same process followed with external candidates, including interview questions, bilingual screening, and other skills tests, as appropriate.

F. On rare occasions, there may be situations where: (1) a position is not posted; or (2) a transfer or promotion is granted due to a sensitive business need, necessitated by other requirements, or implemented prior to the employee being in the position for six (6) months. Exceptions to the standard recruitment process may only be made if there is: (1) a substantiated and documented need to transfer or promote an employee; and (2) sufficient facts to establish that if CalOptima followed the standard procedure, it would result in a demonstrated impairment to the organization or a specific time sensitive project. Without such substantiated business need, the exception should not be made. The Chief Executive Officer (CEO) must approve the exception.

G. If a job offer is extended and accepted by a current employee, subject to the background check and/or any other required medical examinations, if applicable, the start date and transition to the new position will be coordinated between the employee, the new supervisor, and the current supervisor. The employee may need to be available to orient and train a replacement.

III. PROCEDURE

Responsible Party	Action
Employee	1. The employee is responsible for reviewing the job description and/or job posting and ensuring that he or she meets the qualifications and minimum requirements for the job before submitting an application. 2. In order to express interest in an open position, employees are responsible for taking ownership of their own career by completing an internal job application, attaching an updated resume, and submitting the complete package to the Human Resources (HR) Department. 3. Employees participate in the same process followed with external candidates, including an interview, bilingual screening, if applicable, and other skills tests applicable to the selection process.
Hiring Manager	1. Review internal job application with updated resume and notify HR to schedule an interview if the applicant is qualified. 2. Interview the internal applicant. 3. Once a qualified internal applicant has been identified and the Hiring Manager is interested in selecting that applicant to fill an open position, the Hiring Manager shall speak to internal applicant's immediate supervisor as a reference, and review the internal applicant's personnel files for past and current performance reviews with HR. 4. Discuss salary offer with HR. 5. The Hiring Manager will work with the selected employee's current manager to establish a fair start date for both departments.

HR	1. Review internal applicant resumes. 2. Review personnel files for rating of employee for the most current review period and verify if the employee received a Performance Improvement Plan, or a written or final warning within the last six (6) months. 3. If internal applicant appears to meet qualifications and minimum requirements, HR will send the application to Hiring Manager. At the request of the Hiring Manager, HR shall schedule an interview with the internal applicant. If appropriate, the Hiring Manager will conduct a second interview with additional staff members. If the internal applicant is not selected, HR will notify internal applicant of the decision. 4. If an internal applicant is selected to fill an open position, HR will extend an offer, in consultation with the Hiring Manager, based on the employee's experience and skill level, current pay, classification of the open position, and CalOptima's Compensation Program and Salary Schedule. 5. HR will process an Action Form, which is an internal document used by HR in a form similar to the sample form attached hereto and which may be updated from time to time.

IV. ATTACHMENT(S)

A. Action Form (Sample)

V. REFERENCE(S)

A. CalOptima Employee Handbook

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
01/05/2012	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8019	Promotions and Transfers	Administrative
Revised	08/07/2014	GA.8019	Promotions and Transfers	Administrative
Revised	12/01/2016	GA.8019	Promotions and Transfers	Administrative
Revised	12/03/2020	GA.8019	Promotions and Transfers	Administrative

IX. GLOSSARY

Term	Definition
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Performance Improvement Plan	A developmental coaching tool used to document performance and behavioral deficiencies or issues and create an action plan with goals and due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.
Promotion	Occurs when a current employee advances to an open position at a higher classification and salary range from the employee's previous position.
Transfer	Occurs when an employee moves into a new position that is equivalent in its classification and salary range to the employee's previous position.

ACTION FORM

EMPLOYEE INFORMATION

NAME:	EE ID:	PC #:	EFFECTIVE DATE:

LEVEL:	☐ EMP ☐ SUP ☐ MGR ☐ DIR ☐ ~~X~~ EXEC.	Serves OneCare members?	☐ Yes	OCC Members?	☐ Yes	☐ Neither

LOB:	☐ 1 MEDI-CAL	☐ 2 OCC	☐ 3 PACE	☐ 4 ASO	☐ 6 ONECARE	☐ 7 MSSP	☐ 9 COREC

SOURCE:	☐ CALOPTIMA WEBSITE	☐ CAREER FAIR	☐ EE REFERRAL	☐ INTERNET	☐ RECRUITER SOURCED	☐ AGENCY	☐ OTHER

SOURCE NAME:

REASON

☐ DEMOTION	☐ EQUITY ADJUSTMENT	☐ MARKET ADJUSTMENT	☐ NEW HIRE	☐ PROMOTION
☐ RECLASSIFICATION	☐ REHIRE	☐ RESTRUCTURE	☐ SEPARATION	☐ SHIFT CHANGE
☐ ~~PC#~~ STATUS CHANGE	☐ TEMPORARY ~~INCENTIVE~~ ASSIGNMENT	☐ TRANSFER	☐ ~~C&L TRANSLATION~~ TELEWORK	☐ OTHER _____

ACTION

	CURRENT	CHANGE TO
STATUS	☐ Exempt ☐ Non-Exempt	☐ Exempt ☐ Non-Exempt
	☐ FT ☐ PT ☐ As-Needed ☐ Limited Term	☐ FT ☐ PT ☐ As-Needed ☐ Limited Term
	☐ Active ☐ Inactive w/ Benefits ☐ Inactive w/o Benefits	☐ Active ☐ Inactive w/ Benefits ☐ Inactive w/o Benefits
POSITION TITLE		
COST CENTER #		
~~DEPARTMENT~~DEPT NAME		
SUPERVISOR		
SALARY	$	$
SHIFT / TELEWORK		
~~BILINGUAL PAY / CCM PAY~~ SUPPLEMENTAL PAY	☐ AUTO ALLOWANCE _____ ☐ BENEFITS INCOME _____ ☐ BILINGUAL _____ ☐ CCM _____ ☐ RECRUITMENT INCENTIVE _____ ☐ RELOCATION _____ ☐ RETENTION INCENTIVE _____	☐ AUTO ALLOWANCE _____ ☐ BENEFITS INCOME _____ ☐ BILINGUAL _____ ☐ CCM _____ ☐ RECRUITMENT INCENTIVE _____ ☐ RELOCATION _____ ☐ RETENTION INCENTIVE _____ [WT1]

SEPARATION

INVOLUNTARY	☐ ATTENDANCE	☐ DECEASED	☐ END OF ASSIGNMENT	☐ I-9 VIOLATION	☐ JOB ABANDONMENT	☐ JOB ELIMINATION
	☐ LAYOFF / RIF	☐ PERFORMANCE	☐ POLICY VIOLATION	☐ SAM/OIG VIOLATION	☐ OTHER _____	
VOLUNTARY	☐ ADVANCEMENT	☐ CAREER CHANGE	☐ COMMUTE	☐ MANAGEMENT	☐ PAY	
	☐ PERSONAL REASONS	☐ RELOCATION	☐ RETIREMENT	☐ RETURN TO SCHOOL	☐ UNABLE TO RET LOA	
	☐ WORKLOAD	☐ OTHER _____ ~~CHANGE FROM AN / AUTONOMY~~				

LAST DAY WORKED: FINAL PAY CHECK: ☐ DIRECT DEPOSIT ☐ FED-EX ☐ EE TO PICK UP ☐ MAIL HOME ☐ OTHER _____

COMMENTS

☐ EMPLOYEE COPY SENT

APPROVAL

CHIEF SIGNATURE:	PRINT NAME:	DATE:
EXEC. DIRECTOR SIGNATURE:	PRINT NAME:	DATE[WT2]:
DIRECTOR/MANAGER SIGNATURE:	PRINT NAME:	DATE:
HR EXEC. SIGNATURE:	PRINT NAME:	DATE:
HR MANAGER SIGNATURE:	PRINT NAME:	DATE:
COMPENSATION ANALYST SIGNATURE:	PRINT NAME:	DATE:
HR ~~PERSONNEL~~ REPRESENTATIVE SIGNATURE:	PRINT NAME:	DATE:

PAYROLL USE

ADJUSTED PTO ACCRUAL RATE: ( ): _____ x _____ = _____

ADDITIONAL CHECK:	REGULAR PAYOUT:	PTO PAYOUT:
	FLEX PAYOUT:	OTHER:

HUMAN RESOURCES USE[WT3]

HR RECEIVED:

HR ENTERED:

SENT TO PAYROLL:

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ACTION FORM

EMPLOYEE INFORMATION

NAME:	EE ID:	PC #:	EFFECTIVE DATE:

LEVEL:	☐ EMP ☐ SUP ☐ MGR ☐ DIR ☐ EXEC.	Serves OneCare members?	☐ Yes	OCC Members?	☐ Yes	☐ Neither

LOB:	☐ 1 MEDI-CAL	☐ 2 OCC	☐ 3 PACE	☐ 4 ASO	☐ 6 ONECARE	☐ 7 MSSP	☐ 9 COREC

SOURCE:	☐ CALOPTIMA WEBSITE	☐ CAREER FAIR	☐ EE REFERRAL	☐ INTERNET	☐ RECRUITER SOURCED	☐ AGENCY	☐ OTHER

SOURCE NAME:

REASON

☐ DEMOTION	☐ EQUITY ADJUSTMENT	☐ MARKET ADJUSTMENT	☐ NEW HIRE	☐ PROMOTION
☐ RECLASSIFICATION	☐ REHIRE	☐ RESTRUCTURE	☐ SEPARATION	☐ SHIFT CHANGE
☐ STATUS CHANGE	☐ TEMPORARY ASSIGNMENT	☐ TRANSFER	☐ TELEWORK	☐ OTHER _____

ACTION

	CURRENT	CHANGE TO
STATUS	☐ Exempt ☐ Non-Exempt	☐ Exempt ☐ Non-Exempt
	☐ FT ☐ PT ☐ As-Needed ☐ Limited Term	☐ FT ☐ PT ☐ As-Needed ☐ Limited Term
	☐ Active ☐ Inactive w/ Benefits ☐ Inactive w/o Benefits	☐ Active ☐ Inactive w/ Benefits ☐ Inactive w/o Benefits
POSITION TITLE		
COST CENTER #		
DEPT NAME		
SUPERVISOR		
SALARY	$	$
SHIFT / TELEWORK		
SUPPLEMENTAL PAY	☐ AUTO ALLOWANCE _____ ☐ BENEFITS INCOME _____ ☐ BILINGUAL _____ ☐ CCM _____ ☐ RECRUITMENT INCENTIVE _____ ☐ RELOCATION _____ ☐ RETENTION INCENTIVE _____	☐ AUTO ALLOWANCE _____ ☐ BENEFITS INCOME _____ ☐ BILINGUAL _____ ☐ CCM _____ ☐ RECRUITMENT INCENTIVE _____ ☐ RELOCATION _____ ☐ RETENTION INCENTIVE _____

SEPARATION

INVOLUNTARY	☐ ATTENDANCE ☐ DECEASED ☐ END OF ASSIGNMENT ☐ I-9 VIOLATION ☐ JOB ABANDONMENT ☐ JOB ELIMINATION ☐ LAYOFF / RIF ☐ PERFORMANCE ☐ POLICY VIOLATION ☐ SAM/OIG VIOLATION ☐ OTHER _____
VOLUNTARY	☐ ADVANCEMENT ☐ CAREER CHANGE ☐ COMMUTE ☐ MANAGEMENT ☐ PAY ☐ PERSONAL REASONS ☐ RELOCATION ☐ RETIREMENT ☐ RETURN TO SCHOOL ☐ UNABLE TO RET LOA ☐ WORKLOAD ☐ OTHER _____

LAST DAY WORKED: FINAL PAY CHECK: ☐ DIRECT DEPOSIT ☐ FED-EX ☐ EE TO PICK UP ☐ MAIL HOME ☐ OTHER _____

COMMENTS

☐ EMPLOYEE COPY SENT

APPROVAL

CHIEF SIGNATURE:	PRINT NAME:	DATE:
EXEC. DIRECTOR SIGNATURE:	PRINT NAME:	DATE:
DIRECTOR/MANAGER SIGNATURE:	PRINT NAME:	DATE:
HR EXEC. SIGNATURE:	PRINT NAME:	DATE:
HR MANAGER SIGNATURE:	PRINT NAME:	DATE:
COMPENSATION ANALYST SIGNATURE:	PRINT NAME:	DATE:
HR REPRESENTATIVE SIGNATURE:	PRINT NAME:	DATE:

PAYROLL USE

ADJUSTED PTO ACCRUAL RATE: ( ): _____ x _____ = _____			HR RECEIVED:
ADDITIONAL CHECK:	REGULAR PAYOUT:	PTO PAYOUT:	HR ENTERED:
	FLEX PAYOUT:	OTHER:	SENT TO PAYROLL:

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Policy ~~#~~:	GA.8020
Title:	**9/80 Work Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines how CalOptima will ~~establish and~~ administer an alternate workweek schedule commonly referred to as a 9/80 ~~work schedule~~Work Schedule.

II. POLICY

A. ~~CalOptima offers employees a compressed work schedule known as a~~ Based on operational needs, department managers may establish 9/80 ~~work schedule.~~Work Schedules within their departments. A 9/80 Work Schedule is eighty (80) hours of work in a two (2) week period worked over nine (9) days, instead of the traditional ten (10) days. This alternate work schedule ~~provides~~may provide the department with improved coverage and scheduling and employees with another way to manage work and non-work responsibilities ~~by giving.~~

~~A.~~B. Customer Service Remains a Priority: The 9/80 Work Schedule is not an ~~additional day off of work while still achieving~~entitlement and will not be provided at the expense of service to the public and must not adversely affect workloads or the organization's or a ~~full-time schedule (eighty (80) hours in a two (2) week work period).~~ department's ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 Work Schedule based on business needs.

~~B.~~C. Eligibility: After completing ~~the~~ initial on-boarding and training requirements, ~~all~~ full-time ~~CalOptima~~ employees may~~, or may not,~~ be eligible, with supervisory approval, to participate in the 9/80 ~~work schedule~~Work Schedule. An employee must obtain supervisory approval to participate in the 9/80 work schedule. A 9/80 schedule is not available for Director level positions and above, unless approved by the Chief Executive Officer. Initial training requirements may vary by department, but typically do not exceed ninety (90) calendar days. Individual ~~schedules~~9/80 Work Schedules are set based on the pre-determined schedules for payroll and at the discretion of the department manager who will designate the hours for each day, as well as the day off, based on business needs, which shall be consistent with the 9/80 Federal Labor Standards Act (FLSA) Workweek definition. Employees not meeting job standards, ~~or~~ expectations, and/or on a Performance Improvement Plan may not participate in the compressed work schedule until performance standards are met. Managers will review such exceptions with Human Resources (HR) before denying the option. Individuals who do not wish to participate may continue to work a standard forty (40) hour ~~-~~week, eight (8) hours a day. Employees will not be eligible to participate

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in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one (1) alternative at a time.

~~C.~~D. Approval: ~~Before beginning participation in the 9/80 work schedule, an~~An employee must complete a 9/80 Workweek Request Form~~ and,~~ acknowledge that they received and read this policy~~. An employee must~~ , and obtain supervisory approval before submitting the form to HR. Non-~~exempt employees~~Exempt Employees cannot begin their 9/80 ~~work schedule~~Work Schedule until they have received formal approval from HR that outlines the approved 9/80 schedule start date.

~~D.~~E. Transitioning to the 9/80 ~~work schedule~~Work Schedule: When an employee transitions from an eight (8) hour per day workweek to a 9/80 ~~work schedule~~Work Schedule, there will be a necessary change in the beginning of the workweek. This results in a situation in which some of the hours fall into both the old workweek and the new workweek. This could result in fewer or more than eighty (80) hours on an employee's paycheck for that transitional period. If the result is more than eighty (80) hours, a calculation of overtime will be made for ~~employees~~an employee eligible for overtime ~~by Payroll,~~ which includes those hours in both the old and new workweeks, and the greater of the two (2) amounts will be paid to the employee at time and a half. When possible, HR may require a ~~non-exempt employee~~Non-Exempt Employee to work a half (½) day during the transition week to both minimize overtime worked and ensure that the employee receives a full paycheck.

~~E.~~F. Hours of Work: CalOptima daily start times will continue to be flexible with each employee committing to a starting time no earlier than 6:00 a.m. ~~and a scheduled ending time no later than 6:30 p.m.~~ Lunch breaks are pre-approved for one-half (1/2) hour. The option to extend to one (1) hour is based on manager's approval.

~~F.~~G. Paid Time Off (PTO): PTO accrual will remain the same for participating employees. When an employee takes a day off pursuant to CalOptima Policy GA.8018: Paid Time Off, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9) hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9) hour work day for a ~~non-exempt employee~~Non-Exempt Employee, the employee has the option of using one (1) hour of accrued PTO time, or if approved by their supervisor, the option of working one (1) hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take ~~another day~~off eight hours in-lieu of the holiday time off in the same workweek as the holiday.

~~G.~~H. Overtime: ~~An~~It is possible an employee's 9/80 ~~work schedule~~Work Schedule may not generally correspond with CalOptima's pay periods~~. Therefore~~; therefore, adjustments to overtime compensation due cannot be calculated until the completion of the employee's workweek. This may result in one (1) pay period's delay in the employee receiving the ~~additional~~overtime compensation.

~~H. Customer Service Remains a Priority: The 9/80 work schedule is not an entitlement and will not be provided at the expense of service to the public and must not adversely affect the organization's or a department's ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 work schedule based on business needs.~~

I. Employee Conduct: Employees must obtain approval to adjust their work schedule and work hours. Failure to adhere to assigned work hours, tardiness, and excessive absenteeism ~~will~~may lead to revocation of the ~~benefit~~9/80 Work Schedule for the individual. If necessary, as a condition of participating in the 9/80 ~~work schedule~~Work Schedule, employees must agree to work on a scheduled day off for an urgent situation, or as compelled by business needs as determined by the

employee's manager. Non-Exempt employees required to work on their scheduled day off may incur overtime if the total hours worked in the FLSA workweek exceed forty (40) hours. Employees are encouraged to use days off to attend to personal business like medical/dental appointments for themselves and family members.

J. Termination of Program: The 9/80 ~~work schedule~~Work Schedule is an optional program. CalOptima reserves the right to~~.~~, at any time, discontinue the entire program~~,~~ and/or an individual employee's participation in the program, ~~at any time,~~ for any reason at management discretion. Should a ~~Manager~~manager choose to remove an employee from participating in the 9/80 ~~work schedule~~Work Schedule, the ~~Manager~~manager must consult with HR in advance to develop a transition plan. Employees are not allowed to change their work schedules without prior approval from HR and their ~~Manager~~manager. Any changes in schedules by Non-Exempt ~~employees~~Employees must be within the same FLSA workweek.

III. PROCEDURE

Responsible Party	Action
Employee	Complete the 9/80 Workweek Request Form and forward to supervisor for review and approval. ▪ Non-~~exempt employees~~Exempt Employees must submit the applicable request form to HR no less than two (2) weeks in advance of the requested 9/80 start date. ▪ Exempt employees must submit the form at least one (1) week in advance of the requested 9/80 start date.
Supervisor	Review form and approve or deny. ▪ Establish work schedule with the employee. ▪ If approved, ~~supervisor forwards~~forward form to HR in advance of the requested 9/80 Work Schedule start date.
Human Resources	~~HR reviews requests.~~Reviews request and ~~approves~~approve or ~~denies~~deny. ▪ If approved, ~~HR determines~~determine an employee's new workweek and ~~sends~~send an email to the employee to outline when the new workweek will begin and what hours must be worked in the transition week to minimize overtime.

IV. ATTACHMENT(S)

A. Friday 9/80 Workweek Request Form (Exempt)
B. Friday 9/80 Workweek Request Form (Non-Exempt)
C. Monday 9/80 Workweek Request Form (Exempt)
D. Monday 9/80 Workweek Request Form (Non-Exempt)

V. REFERENCE(S)

A. CalOptima Employee Handbook
~~B. CalOptima Policy GA.8000: Glossary of Terms~~
~~C.~~B. CalOptima Policy GA.8018: Paid Time Off
~~D.~~C. Title 29, Code of Federal Regulations (C.F.R.), §778.105

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
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8020	9/80 Work Schedule	Administrative
Revised	02/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	10/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	12/01/2016	GA.8020	9/80 Work Schedule	Administrative
Revised	12/03/2020	GA.8020	9/80 Work Schedule	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 ~~work schedule~~Work Schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
9/80 Federal Labor Standards Act (FLSA) Workweek	Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24) hour periods, or one hundred sixty-eight (168) hours (29 C.F.R. §778.105). The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time, and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and HR can answer questions about day divides.
Exempt Employee	~~Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries.~~ Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and ~~is defined by Human Resources for each position~~consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. For purposes of this policy, e~~E~~xempt employees do not earn overtime compensation.
Non-Exempt Employee	~~Includes~~Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on ~~an~~a hourly basis and are eligible for overtime compensation ~~as required by~~. Although an employee's classification may qualify for applicable federal ~~wage and hour laws.~~ exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Performance Improvement Plan	A developmental coaching tool used to ~~improve employee behavior and/or to address~~document performance and behavioral deficiencies ~~identified in the annual~~ or issues and create an action plan with goals and due dates to help employees correct and/or improve performance ~~review. The plan includes measurable expectations and accountability meetings~~and behavior while still holding them accountable for past performance.

Policy:	GA.8020
Title:	**9/80 Work Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines how CalOptima will administer an alternate workweek schedule commonly referred to as a 9/80 Work Schedule.

II. POLICY

A. Based on operational needs, department managers may establish 9/80 Work Schedules within their departments. A 9/80 Work Schedule is eighty (80) hours of work in a two (2) week period worked over nine (9) days, instead of the traditional ten (10) days. This alternate work schedule may provide the department with improved coverage and scheduling and employees with another way to manage work and non-work responsibilities.

B. Customer Service Remains a Priority: The 9/80 Work Schedule is not an entitlement and will not be provided at the expense of service to the public and must not adversely affect workloads or the organization's or a department's ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 Work Schedule based on business needs.

C. Eligibility: After completing initial on-boarding and training requirements, full-time employees may be eligible, with supervisory approval, to participate in the 9/80 Work Schedule. An employee must obtain supervisory approval to participate in the 9/80 work schedule. A 9/80 schedule is not available for Director level positions and above, unless approved by the Chief Executive Officer. Initial training requirements may vary by department, but typically do not exceed ninety (90) calendar days. Individual 9/80 Work Schedules are set based on the pre-determined schedules for payroll and at the discretion of the department manager who will designate the hours for each day, as well as the day off, based on business needs, which shall be consistent with the 9/80 Federal Labor Standards Act (FLSA) Workweek definition. Employees not meeting job standards, expectations, and/or on a Performance Improvement Plan may not participate in the compressed work schedule until performance standards are met. Managers will review such exceptions with Human Resources (HR) before denying the option. Individuals who do not wish to participate may continue to work a standard forty (40) hour-week, eight (8) hours a day. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one (1) alternative at a time.

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D. Approval: An employee must complete a 9/80 Workweek Request Form, acknowledge that they received and read this policy, and obtain supervisory approval before submitting the form to HR. Non-Exempt Employees cannot begin their 9/80 Work Schedule until they have received formal approval from HR that outlines the approved 9/80 schedule start date.

E. Transitioning to the 9/80 Work Schedule: When an employee transitions from an eight (8) hour per day workweek to a 9/80 Work Schedule, there will be a necessary change in the beginning of the workweek. This results in a situation in which some of the hours fall into both the old workweek and the new workweek. This could result in fewer or more than eighty (80) hours on an employee's paycheck for that transitional period. If the result is more than eighty (80) hours, a calculation of overtime will be made for an employee eligible for overtime, which includes those hours in both the old and new workweeks, and the greater of the two (2) amounts will be paid to the employee at time and a half. When possible, HR may require a Non-Exempt Employee to work a half (½) day during the transition week to both minimize overtime worked and ensure that the employee receives a full paycheck.

F. Hours of Work: CalOptima daily start times will continue to be flexible with each employee committing to a starting time no earlier than 6:00 a.m. Lunch breaks are pre-approved for one-half (1/2) hour. The option to extend to one (1) hour is based on manager's approval.

G. Paid Time Off (PTO): PTO accrual will remain the same for participating employees. When an employee takes a day off pursuant to CalOptima Policy GA.8018: Paid Time Off, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9) hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9) hour work day for a Non-Exempt Employee, the employee has the option of using one (1) hour of accrued PTO time, or if approved by their supervisor, the option of working one (1) hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take off eight hours in-lieu of the holiday time off in the same workweek as the holiday.

H. Overtime: It is possible an employee's 9/80 Work Schedule may not generally correspond with CalOptima's pay periods; therefore, adjustments to overtime compensation due cannot be calculated until the completion of the employee's workweek. This may result in one (1) pay period's delay in the employee receiving the overtime compensation.

I. Employee Conduct: Employees must obtain approval to adjust their work schedule and work hours. Failure to adhere to assigned work hours, tardiness, and excessive absenteeism may lead to revocation of the 9/80 Work Schedule for the individual. If necessary, as a condition of participating in the 9/80 Work Schedule, employees must agree to work on a scheduled day off for an urgent situation, or as compelled by business needs as determined by the employee's manager. Non-Exempt employees required to work on their scheduled day off may incur overtime if the total hours worked in the FLSA workweek exceed forty (40) hours. Employees are encouraged to use days off to attend to personal business like medical/dental appointments for themselves and family members.

J. Termination of Program: The 9/80 Work Schedule is an optional program. CalOptima reserves the right to, at any time, discontinue the entire program and/or an individual employee's participation in the program, for any reason at management discretion. Should a manager choose to remove an employee from participating in the 9/80 Work Schedule, the manager must consult with HR in advance to develop a transition plan. Employees are not allowed to change their work schedules without prior approval from HR and their manager. Any changes in schedules by Non-Exempt Employees must be within the same FLSA workweek.

III. PROCEDURE

Responsible Party	Action
Employee	Complete the 9/80 Workweek Request Form and forward to supervisor for review and approval. ▪ Non-Exempt Employees must submit the applicable request form to HR no less than two (2) weeks in advance of the requested 9/80 start date. ▪ Exempt employees must submit the form at least one (1) week in advance of the requested 9/80 start date.
Supervisor	Review form and approve or deny. ▪ Establish work schedule with the employee. ▪ If approved, forward form to HR in advance of the requested 9/80 Work Schedule start date.
Human Resources	Reviews request and approve or deny. ▪ If approved, determine an employee's new workweek and send an email to the employee to outline when the new workweek will begin and what hours must be worked in the transition week to minimize overtime.

IV. ATTACHMENT(S)

A. Friday 9/80 Workweek Request Form (Exempt)
B. Friday 9/80 Workweek Request Form (Non-Exempt)
C. Monday 9/80 Workweek Request Form (Exempt)
D. Monday 9/80 Workweek Request Form (Non-Exempt)

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8018: Paid Time Off
C. Title 29, Code of Federal Regulations (C.F.R.), §778.105

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
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8020	9/80 Work Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	10/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	12/01/2016	GA.8020	9/80 Work Schedule	Administrative
Revised	12/03/2020	GA.8020	9/80 Work Schedule	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 Work Schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
9/80 Federal Labor Standards Act (FLSA) Workweek	Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24) hour periods, or one hundred sixty-eight (168) hours (29 C.F.R. §778.105). The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time, and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and HR can answer questions about day divides.
Exempt Employee	Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. For purposes of this policy, exempt employees do not earn overtime compensation.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on a hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Performance Improvement Plan	A developmental coaching tool used to document performance and behavioral deficiencies or issues and create an action plan with goals and due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.

Friday 9/80 Workweek Request Form
Declaration of Hours - Exempt Employees

I, the undersigned employee, wish to participate in CalOptima's 9/80 Compressed Work Schedule Program.

I am requesting to work the following schedule, designating this day off:

1st Friday ☐ or 2nd Friday ☐

Lunch Break: ☒ one hour. **From**: 12:00 p.m. **to** 1:00 p.m.

**Fill in below which Friday you'll be off. The hours for the 8-hour Friday worked will be 8:00 a.m. to 5:00 p.m.*

Week 1 of pay period	Monday		Tuesday		Wednesday		Thursday		Friday	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm		
Week 2 of pay period	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm		

Provisions:

1) The 9/80 program may be modified or discontinued at any time.
2) My participation in the 9/80 Work Schedule is at the discretion of my Supervisor. As a condition of participating in the 9/80 work schedule, I agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by my supervisor/manager.
3) The workweek will be subjected to a "Day Divide," meaning that my workweek will begin half-way through my 8 hour day (which is split in half for pay purposes, leaving 4 hours in one week and 4 hours in the following week, ensuring that 40 hours of work are performed in each workweek).
4) **I must notify HR if I plan to permanently change my 9/80 day off or if I end the 9/80 program**.

I, the Employee, acknowledge that I have read and understand all the policy provisions contained in CalOptima Policy #GA. 8020: 9/80 Work Schedule and Employee Handbook and agree to abide by the guidelines and requirements as stated.

Employee Name (*Print*): _____ Employee Name (*Sign*): _____

Date: _____ 4 Digit Employee ID #: _____

I, the Supervisor, acknowledge and understand the above provisions and guidelines as stated.

Supervisor Name (*Print*): _____ Supervisor Name (*Sign*): _____

Date: _____

Please give the original signed form to Human Resources and a copy to your Manager.

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Date Requesting to Start (must be beginning of pay period): _____

HR Only
Approved: _____ Date: _____ Date to Start: _____
Denied: _____ Date: _____ Reason: _____

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Friday 9/80 Workweek Request Form
Declaration of Hours - Non-Exempt Employees

I, the undersigned employee, wish to participate in CalOptima's 9/80 Compressed Work Schedule Program.

- I am currently working a 9/80 schedule: ☐ Yes ☐ No If yes, my current day off is: _____
- I am requesting to work the following schedule, designating this day off: 1st Friday ☐ or 2nd Friday ☐

**Fill in below your work hours according to the schedule options on page 2 and which Friday you'll be off. The opposite Friday must be your 8-hour day.*

- **My Start Time Will Be**: _____ **My End Time Will Be**: _____
- Lunch Break: ☒ half hour. **From**: _____ **To**: _____

Week 1 of pay period	Monday		Tuesday		Wednesday		Thursday		Friday	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
Week 2 of pay period	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time

Provisions:

1) The 9/80 program may be modified or discontinued at any time.
2) My participation in the 9/80 Work Schedule is at the discretion of my Supervisor. As a condition of participating in the 9/80 work schedule, I agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by my supervisor/manager.
3) The workweek will be subjected to a "Day Divide," meaning that my workweek will begin half-way through my 8 hour day (which is split in half for pay purposes, leaving 4 hours in one week and 4 hours in the following week, ensuring that 40 hours of work are performed in each workweek).
4) **I cannot start working a 9/80 schedule, change a 9/80 schedule, or end a 9/80 schedule until Human Resources has confirmed a transition schedule and date for this alternative workweek arrangement.**

I, the Employee, acknowledge that I have read and understand all the policy provisions contained in CalOptima Policy #GA. 8020: 9/80 Work Schedule and Employee Handbook and agree to abide by the guidelines and requirements as stated.

Employee Name (*Print*): _____ Employee Name (*Sign*): _____

Date: _____ 4 Digit Employee ID #: _____

I, the Supervisor, acknowledge and understand the above provisions and guidelines as stated.

Supervisor Name (*Print*): _____ Supervisor Name (*Sign*): _____

Date: _____ Date Requesting to Start (must be beginning of pay period): _____

Please give the original signed form to Human Resources and a copy to your Manager.

HR Only
Approved: _____ Date: _____ Date to Start: _____
Denied: _____ Date: _____ Reason: _____

Friday 9/80 Schedule Options for Non-Exempt Employees

(no exceptions to these schedules are permitted)

Start Time	End Time	Lunch Start Time	Lunch End Time	Notes
6:00 a.m.	3:30 p.m.	10:00 a.m.	10:30 a.m.	2nd Friday off only
7:00 a.m.	4:30 p.m.	11:00 a.m.	11:30 p.m.	1st or 2nd Friday off
7:30 a.m.	5:00 p.m.	11:30 p.m.	12:00 p.m.	1st or 2nd Friday off
8:00 a.m.	5:30 p.m.	12:00 p.m.	12:30 p.m.	1st or 2nd Friday off
8:30 a.m.	6:00 p.m.	12:30 p.m.	1:00 p.m.	1st or 2nd Friday off
9:00 a.m.	6:30 p.m.	1:00 p.m.	1:30 p.m.	1st or 2nd Friday off

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Monday 9/80 Workweek Request Form
Declaration of Hours - Exempt Employees

I, the undersigned employee, wish to participate in CalOptima's 9/80 Compressed Work Schedule Program.

I am requesting to work the following schedule, designating this day off:

1st Monday ☐ or 2nd Monday ☐

Lunch Break: ☒ one hour. **From**: 12:00 p.m. **to** 1:00 p.m.

**Fill in below which Monday you'll be off. The hours for the 8-hour Monday worked will be 8:00 a.m. to 5:00 p.m.*

Week 1 of pay period	Monday		Tuesday		Wednesday		Thursday		Friday	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
			8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm
Week 2 of pay period	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
			8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm

Provisions:

1) The 9/80 program may be modified or discontinued at any time.
2) My participation in the 9/80 Work Schedule is at the discretion of my Supervisor. As a condition of participating in the 9/80 work schedule, I agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by my supervisor/manager.
3) The workweek will be subjected to a "Day Divide," meaning that my workweek will begin half-way through my 8 hour day (which is split in half for pay purposes, leaving 4 hours in one week and 4 hours in the following week, ensuring that 40 hours of work are performed in each workweek).
4) **I must notify HR if I plan to permanently change my 9/80 day off or if I end the 9/80 program**.

I, the Employee, acknowledge that I have read and understand all the policy provisions contained in CalOptima Policy #GA. 8020: 9/80 Work Schedule and Employee Handbook and agree to abide by the guidelines and requirements as stated.

Employee Name (*Print*): _____ Employee Name (*Sign*): _____

Date: _____ 4 Digit Employee ID #: _____

I, the Supervisor, acknowledge and understand the above provisions and guidelines as stated.

Supervisor Name (*Print*): _____ Supervisor Name (*Sign*): _____

Date: _____

Please give the original signed form to Human Resources and a copy to your Manager.

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Date Requesting to Start (must be beginning of pay period): _____

HR Only
Approved: _____ Date: _____ Date to Start: _____
Denied: _____ Date: _____ Reason: _____

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Monday 9/80 Workweek Request Form
Declaration of Hours - Non-Exempt Employees

I, the undersigned employee, wish to participate in CalOptima's 9/80 Compressed Work Schedule Program.

- I am currently working a 9/80 schedule: ☐ Yes ☐ No If yes, my current day off is: _____
- I am requesting to work the following schedule, designating this day off: 1st Monday ☐ or 2nd Monday ☐

**Fill in below your work hours according to the schedule options on page 2 and which Monday you'll be off. The opposite Monday must be your 8-hour day.*

- **My Start Time Will Be**: _____ **My End Time Will Be**: _____
- Lunch Break: ☒ half hour. **From**: _____ **To**: _____

Week 1 of pay period	Monday		Tuesday		Wednesday		Thursday		Friday	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
Week 2 of pay period	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time

Provisions:

1) The 9/80 program may be modified or discontinued at any time.
2) My participation in the 9/80 Work Schedule is at the discretion of my Supervisor. As a condition of participating in the 9/80 work schedule, I agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by my supervisor/manager.
3) The workweek will be subjected to a "Day Divide," meaning that my workweek will begin half-way through my 8 hour day (which is split in half for pay purposes, leaving 4 hours in one week and 4 hours in the following week, ensuring that 40 hours of work are performed in each workweek).
4) **I cannot start working a 9/80 schedule, change a 9/80 schedule, or end a 9/80 schedule until Human Resources has confirmed a transition schedule and date for this alternative workweek arrangement.**

I, the Employee, acknowledge that I have read and understand all the policy provisions contained in CalOptima Policy #GA. 8020: 9/80 Work Schedule and Employee Handbook and agree to abide by the guidelines and requirements as stated.

Employee Name (*Print*): _____ Employee Name (*Sign*): _____

Date: _____ 4 Digit Employee ID #: _____

I, the Supervisor, acknowledge and understand the above provisions and guidelines as stated.

Supervisor Name (*Print*): _____ Supervisor Name (*Sign*): _____

Date: _____ Date Requesting to Start (must be beginning of pay period): _____

Please give the original signed form to Human Resources and a copy to your Manager.

HR Only
Approved: _____ Date: _____ Date to Start: _____
Denied: _____ Date: _____ Reason: _____

Monday 9/80 Schedule Options for Non-Exempt Employees

(no exceptions to these schedules are permitted)

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7:00 a.m.	4:30 p.m.	11:00 a.m.	11:30 p.m.	1st or 2nd Monday off
7:30 a.m.	5:00 p.m.	11:30 p.m.	12:00 p.m.	1st or 2nd Monday off
8:00 a.m.	5:30 p.m.	12:00 p.m.	12:30 p.m.	1st or 2nd Monday off
8:30 a.m.	6:00 p.m.	12:30 p.m.	1:00 p.m.	1st or 2nd Monday off
9:00 a.m.	6:30 p.m.	1:00 p.m.	1:30 p.m.	1st or 2nd Monday off

Policy:	GA.8026
Title:	**Employee Referral Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides for an opportunity for employees to receive compensation for individuals referred to and hired by CalOptima.

II. POLICY

A. Employee referrals are a valuable and cost-effective source ~~of~~to find and hire the best new ~~employees.~~talent. In times of recruiting challenges, CalOptima may choose to reward the recruiting efforts of employees by awarding a bonus to employees whose referrals are hired, in accordance with the following guidelines. Exceptions to the policy may be made, in special circumstances, by the Human Resources (HR) Department.

B. Eligibility

1. Employees will be eligible to receive bonuses for referrals if all of the following conditions are met:

   a. The employee making the referral is a regular full-time or part-time employee;

   b. The referred applicant is hired for a regular full-time or part-time position at CalOptima;

   c. The referred applicant remains continuously employed by CalOptima and is in Good Standing for a minimum of four (4) months;

   d. The employee making the referral is employed by CalOptima at the conclusion of the four (4) month period; and

   e. The applicant was not already identified through another source.

   f. All regular full~~ and~~-time or part-time employees are eligible to receive a referral bonus, except:

      i. Members of the HR Department;

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ii. Employees in supervisory positions who refer applicants for employment within their own work units; or

iii. Members of the Executive Staff~~; and~~

~~iv. Temporary or contract workers.~~

g. ~~All referrals~~ A referral from an eligible employee will be considered for the ~~employee~~ referral bonus except~~:~~ if the person being referred is::

i. ~~Referrals of~~A former or current employee of CalOptima;

~~i.~~ A former or current ~~employees of CalOptima;~~

ii. ~~Former or current consultants~~consultant to CalOptima; ~~and~~or

~~iii. Temporary workers who currently work on-site or have worked with CalOptima in the past.~~

iii. A temporary worker who currently works or worked for CalOptima in the past, unless the temporary employee meets all of the following: (1) was referred to CalOptima by an eligible employee; (2) was then referred by CalOptima to a temporary staffing agency; (3) worked as a temporary employee at CalOptima; and (4) was then subsequently hired immediately following work as a temporary employee at CalOptima and remains continuously employed as a CalOptima employee for a minimum or four (4) months.

C. Awards

1. There is no limit to the number of applicants an employee may refer. For each referred applicant who is hired under the terms of this policy, the employee may receive a bonus of a specified amount before taxes. The bonus amount, which will be set in a fair and consistent manner, is dependent on the position and at the discretion of the HR Department. If the referred applicant indicates more than one (1) employee name as a referral, the HR Department will select the first employee listed to receive the referral bonus. Employees will receive bonuses with their paychecks (in a separate check) within two (2) to four (4) weeks after the four (4) month minimum employment period.

D. The Employee Referral Program is provided only to the extent that budgeted funds are available. CalOptima is under no obligation to fund or continue the Employee Referral Program.

III. PROCEDURE

Responsible Party	Action
Employee	**1.** Employee's name needs to be entered by the applicant at time of completing the online application through the CalOptima website, under "How did you hear about us?"
Human Resources	1. Determine the amount of the bonus payment appropriate to the position prior to advertising for the open position; 2. If the referred applicant indicates more than one (1) employee name as a referral, the first employee listed will receive the referral bonus; 3. Notify referring employees of candidates who were hired;

Responsible Party	Action
	4. Track all hired referrals through the waiting period; 5. Certify that both employees are still employed at the end of the four (4) month waiting period; 6. Ensure sufficient funds in budget for bonus payment; 7. Approve the bonus payment; and 8. Send Action Form to the Payroll Department.
Payroll Department	1. Upon receipt of HR's request for payment, the Payroll Department will issue the bonus payment to the referring employee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Employee Handbook

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/06/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
01/05/2012	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8026	Employee Referral Program	Administrative
Revised	06/04/2015	GA.8026	Employee Referral Program	Administrative
Revised	04/06/2017	GA.8026	Employee Referral Program	Administrative
Revised	12/03/2020	GA.8026	Employee Referral Program	Administrative

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IX. GLOSSARY

Term	Definition
Employee Referral Program	A bonus program for employees whose applicant referrals are hired, and the eligibility conditions are met.
Executive Staff	Any CalOptima employee whose position title is Executive Director or Chief Officer of one (1) or more departments.
Good Standing	The employee has at least a ~~fully meets expectations job~~satisfactory level of performance ~~rating~~ on their most recent evaluation and has not received written ~~disciplinary~~corrective action within the last six (6) months.

Policy:	GA.8026
Title:	**Employee Referral Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides for an opportunity for employees to receive compensation for individuals referred to and hired by CalOptima.

II. POLICY

A. Employee referrals are a valuable and cost-effective source to find and hire the best new talent. In times of recruiting challenges, CalOptima may choose to reward the recruiting efforts of employees by awarding a bonus to employees whose referrals are hired, in accordance with the following guidelines. Exceptions to the policy may be made, in special circumstances, by the Human Resources (HR) Department.

B. Eligibility

1. Employees will be eligible to receive bonuses for referrals if all of the following conditions are met:

   a. The employee making the referral is a regular full-time or part-time employee;

   b. The referred applicant is hired for a regular full-time or part-time position at CalOptima;

   c. The referred applicant remains continuously employed by CalOptima and is in Good Standing for a minimum of four (4) months;

   d. The employee making the referral is employed by CalOptima at the conclusion of the four (4) month period; and

   e. The applicant was not already identified through another source.

   f. All regular full-time or part-time employees are eligible to receive a referral bonus, except:

      i. Members of the HR Department;

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ii. Employees in supervisory positions who refer applicants for employment within their own work units; or

iii. Members of the Executive Staff

g. A referral from an eligible employee will be considered for the referral bonus except if the person being referred is::

i. A former or current employee of CalOptima;

ii. A former or current consultant to CalOptima; or

iii. A temporary worker who currently works or worked for CalOptima in the past, unless the temporary employee meets all of the following: (1) was referred to CalOptima by an eligible employee; (2) was then referred by CalOptima to a temporary staffing agency; (3) worked as a temporary employee at CalOptima; and (4) was then subsequently hired immediately following work as a temporary employee at CalOptima and remains continuously employed as a CalOptima employee for a minimum or four (4) months.

C. Awards

1. There is no limit to the number of applicants an employee may refer. For each referred applicant who is hired under the terms of this policy, the employee may receive a bonus of a specified amount before taxes. The bonus amount, which will be set in a fair and consistent manner, is dependent on the position and at the discretion of the HR Department. If the referred applicant indicates more than one (1) employee name as a referral, the HR Department will select the first employee listed to receive the referral bonus. Employees will receive bonuses with their paychecks (in a separate check) within two (2) to four (4) weeks after the four (4) month minimum employment period.

D. The Employee Referral Program is provided only to the extent that budgeted funds are available. CalOptima is under no obligation to fund or continue the Employee Referral Program.

III. PROCEDURE

Responsible Party	Action
Employee	**1.** Employee's name needs to be entered by the applicant at time of completing the online application through the CalOptima website, under "How did you hear about us?"
Human Resources	1. Determine the amount of the bonus payment appropriate to the position prior to advertising for the open position; 2. If the referred applicant indicates more than one (1) employee name as a referral, the first employee listed will receive the referral bonus; 3. Notify referring employees of candidates who were hired; 4. Track all hired referrals through the waiting period; 5. Certify that both employees are still employed at the end of the four (4) month waiting period;

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Responsible Party	Action
	6. Ensure sufficient funds in budget for bonus payment; 7. Approve the bonus payment; and 8. Send Action Form to the Payroll Department.
Payroll Department	1. Upon receipt of HR's request for payment, the Payroll Department will issue the bonus payment to the referring employee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Employee Handbook

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/06/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
01/05/2012	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8026	Employee Referral Program	Administrative
Revised	06/04/2015	GA.8026	Employee Referral Program	Administrative
Revised	04/06/2017	GA.8026	Employee Referral Program	Administrative
Revised	12/03/2020	GA.8026	Employee Referral Program	Administrative

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IX. GLOSSARY

Term	Definition
Employee Referral Program	A bonus program for employees whose applicant referrals are hired, and the eligibility conditions are met.
Executive Staff	Any CalOptima employee whose position title is Executive Director or Chief Officer of one (1) or more departments.
Good Standing	The employee has at least a satisfactory level of performance on their most recent evaluation and has not received written corrective action within the last six (6) months.

Policy:	GA.8047
Title:	**Reduction in Force**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	02/01/2014
Review Date:	12/03/2020

Applicable to:

- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

I. PURPOSE

This policy defines how CalOptima shall administer a Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima to eliminate positions.

II. POLICY

A. All CalOptima employees are At-Will employees. An employee is terminated as part of the RIF program through no fault of his or her own. The RIF is considered an involuntary separation of employment that is intended to be permanent as a result of:

1. Lack of work, changing priorities, budgetary constraints, or other business reasons; or

2. A determination by management that, due to business reasons, an employee's performance, or contribution to the business (although satisfactory), does not meet the needs of the business.

B. As part of the RIF program, CalOptima shall evaluate the business needs of the organization and the need for particular positions. CalOptima shall take into account the relative value of work performed by specific employees, including, but not limited to, performance, qualifications, discipline, attendance, and length of service, so that CalOptima can continue to provide the highest level of service possible with a reduced work force. In implementing an RIF program, CalOptima may consider, depending on the circumstances, various factors, including, but not limited to, the following (which are not presented in any order of importance):

1. CalOptima's need, or lack thereof, for the position occupied by the employee;

2. The contributions which the employee has made to the success of the organization, and the perceived likelihood of contributions to the success of the business in the foreseeable future;

3. Demonstrated high quality performance on the same, or related, assignments;

4. Versatility and ability in applying pertinent skills and experience to current and expected business requirements;

5. The employee's length of service in the particular position to be retained;

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6. The employee's length of service with CalOptima;

7. CalOptima's need to maintain continuity with respect to a particular project or team; and

8. The more recent performance of the employee compared to others in the same classification.

C. In cases where management determines the various factors considered are essentially equal between two (2) or more employees, length of service in the position and/or length of service at CalOptima may be the deciding factor in determining which employee, or employees, shall be retained. In the event an employee who is being laid off has greater length of service in the position and/or length of service at CalOptima than an employee, or employees, being retained within the same classification and specialty in the impacted department, CalOptima must document the basis, in the judgment of management, the employee with less length of service is better suited for retention.

D. The Human Resources Department shall work closely with the Legal Affairs Department to implement the RIF program to ensure compliance with all applicable federal, state, and local laws and regulations.

E. An employee terminated as part of the RIF program must continue to perform his or her duties satisfactorily until the Separation Date. Otherwise, the employee may be subject to disciplinary action, up to and including termination, prior to the specified Separation Date, consistent with CalOptima Policy GA.8022: ~~Progressive Discipline~~Performance and Behavior Standards. An employee terminated as a result of failure to perform duties satisfactorily until the Separation Date shall not be qualified to receive any benefits administered as part of the RIF program.

F. Limitations to Eligibility

1. An employee terminated as part of the RIF program will not be eligible to receive benefits under the plan if the employee:

   a. Is terminated for cause, including but not limited to, failure to meet the performance requirements of the position, policy violation, theft, gross misconduct, etc.; or

   b. Fails, or refuses, to return all CalOptima property in the employee's possession, and/or fails to clear all expense and other financial accounts, as of the date of termination. (Examples of CalOptima property include, but are not limited to: CalOptima Security badges, office keys any and all CalOptima documents, files, and computers. Examples of accounts to be cleared include, but are not limited to, the completion and reconciliation of expense accounts); or

   c. Resigns, or otherwise voluntarily terminates, his or her employment; or

   d. Is terminated by temporary layoff, or furlough, except that if CalOptima elects to convert the temporary layoff, or furlough, into a permanent layoff, severance pay may then be payable as of the effective date of permanent layoff, if the employee otherwise is eligible for benefits under the RIF program; or,

   e. Is on a leave of absence, except that if an employee is released to return to work from an approved leave of absence and CalOptima has no assignment for the employee, he/she may be eligible for benefits under the RIF program; or

   f. Is offered a comparable position within CalOptima in lieu of termination, but fails, or refuses, to accept it; or

g. Is terminated because of CalOptima's sale, or transfer, of all, or part, of its assets and his/her employment continues with the agency, or transferee organization, after the transfer has been completed; or

h. Is terminated in connection with the "outsourcing" of operational functions, and he/she is offered comparable employment by the outsourcing vendor. For this purpose, comparable employment shall be defined as a position with substantially the same duties, at the same, or greater, compensation and comparable benefits, which does not require relocation, as defined by the IRS; or

i. Is terminated from employment for failure to return to work following a leave of absence; or

j. Retires; or

k. Is deceased, at which time eligibility for benefits under the RIF program will end and all such benefit payments, if any, will cease; or

l. Is separated from CalOptima because he or she is no longer able to perform the essential functions of his/her job (with or without reasonable accommodation) because of a disability; or

m. Is a temporary employee, intern/volunteer, independent contractor or consultant; or

n. Is an employee employed by CalOptima pursuant to a written contract containing provisions for severance benefits; or

o. Is convicted of a crime involving an abuse of his or her office, or position.

G. This policy sets forth general guidelines to observe in the event of a RIF; however, this policy may be subject to change, deviation, or modification, without notice, depending on the circumstances. Any decision to deviate from this policy in any particular case shall be subject to the discretion of the Chief Executive Officer (CEO).

H. Applicable provisions of this policy may also be used to address employee separations or terminations, other than a RIF, where appropriate, at the discretion of the CEO.

III. PROCEDURE

A. Affected Positions: Following an evaluation of CalOptima's business needs, CalOptima, through appropriate Executive Officers and the Human Resources (HR) Department (hereinafter referred to as the "management"), will identify and determine the positions that will be eliminated and/or affected by a RIF. Management also has the discretion to determine the manner in which the RIF will occur; however, notification to the HR Department should precede the implementation of the RIF.

B. Determinations: Determinations concerning the evaluation of employees, the considerations evaluated, and final recommendations should be made by the employee's immediate supervisor and/or manager with the next higher management level. Documentation of all considerations evaluated should be furnished to HR and approved by management prior to any notification to the employee affected by the RIF.

C. Transfers or Downgrades: Depending on CalOptima's business needs, an employee impacted by the RIF may be offered a downgrade (a lower position and/or reduction in base pay) or lateral transfer (an equivalent position and/or equivalent base pay) to another open job position for which he or she is, in the judgment of management, most qualified even though it is a job position or classification that the employee has not previously held. An employee impacted by the RIF who is offered a lateral transfer, or downgrade, may be provided the option of layoff. HR shall determine, on a case-by-case basis, the time period appropriate to accept, or decline, such job offer.

D. Employee Notices: Employees who are to be laid off as a result of the RIF should be notified of such reduction only after all necessary approvals have been obtained. An employee notified of a lay off must continue to work up to the Separation Date specified in the notice, unless management decides otherwise. An employee notified of his or her lay off, as a result of the RIF, may not subsequently be placed on a leave of absence (LOA) without prior approval of the Executive Director of HR.

E. Severance: Severance pay may be offered, if approved by the CEO and HR, upon an employee's separation from service when it is deemed appropriate due to special circumstances. If severance pay is authorized and offered, it will be paid in accordance with the following, unless otherwise defined in a separate employee agreement, or approved by the CEO:

1. Two (2) weeks of pay at the rate of the Annual Earnings for employees with less than two (2) years of service and more than ninety (90) days; or

2. One (1) week of pay at the rate of the Annual Earnings for each completed year of service, with a maximum of sixteen (16) weeks, for employees with two (2) years or more of service.

F. Employees on a Leave of Absence: If an employee is on a Leave of Absence (LOA), and his or her position is terminated as part of the RIF, CalOptima will not terminate the LOA early to implement the RIF program. The employee will be laid off at the scheduled, or required, conclusion of the LOA. This paragraph does not apply to employees on Personal LOA, pursuant to CalOptima Policy GA.8038: Personal Leave of Absence.

G. Release Agreement: In order to be eligible for the severance pay, if offered, an eligible employee must fully complete and execute a Separation Agreement provided by CalOptima, in a form approved by the Legal Affairs Department, at, or near the time of, termination. This Separation Agreement includes a release of all known and unknown claims the employee has, or may have, against CalOptima, as well as an agreement of confidentiality, non-disparagement, and non-solicitation. To be eligible for the severance pay, the Separation Agreement must be signed by the employee and must become irrevocable, in accordance with applicable law.

H. Payment Method: All wages earned and unpaid, including paid time off (PTO) and flex holidays, on the specified Separation Date will be paid to the employee in accordance with CalOptima's pay schedule and not necessarily on the employee's Separation Date. CalOptima may make payment of severance pay, if an employee is eligible, in accordance with the CalOptima payroll schedule as if the recipient were still employed or in a lump sum payment, following a seven (7) day waiting period, where applicable, and after receipt of the fully executed and irrevocable Separation Agreement and/or any other agreement. Payment in installments will be equal to the employee's bi-weekly Annual Earnings wages, less applicable taxes and deductions, including benefits, if applicable, until the agreed upon sum has been distributed. Eligible employees receiving payment in installments shall be required to remain reasonably available during the time period the employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters. Payment by lump sum will be distributed on CalOptima's next regularly scheduled

payday and will be equal to the amount the employee would have made in wages for the applicable number of weeks of severance pay offered, less applicable taxes and deductions.

I. Taxes: CalOptima shall reduce all severance pay by all applicable federal, state, or local tax withholdings.

J. Termination of Severance Pay: If a former employee is receiving severance pay through periodic payments as described in Section III.H., severance pay will immediately cease if CalOptima discovers that the employee:

1. Has failed to return all CalOptima property; or

2. Has disclosed or used confidential information about CalOptima for the benefit of a third party; or

3. Has defamed CalOptima; or

4. Has been hired on a full-time basis by another employer; or

5. Has failed to remain reasonably available to respond to CalOptima questions, or work-related matters.

6. Has attempted to entice other employees of CalOptima to work for a competitor; or

7. Has been convicted of a crime involving an abuse of his or her office, or position.

K. Death: If a former employee dies before all payments have been made, severance payments will cease. No benefits will continue to a beneficiary.

L. Returning to Work: If an employee is eligible for and receives benefits under this Policy, and that employee later returns to work for CalOptima before receiving all payments under this Policy, further severance payments will cease effective on the rehire date. If the employee later becomes eligible for benefits under this Policy, the subsequent severance payment calculated based on the total years of service will be reduced by the amount of severance payments previously paid.

M. Retirement Benefits: The receipt of severance pay under this Policy shall have no effect on the employee's right, if any, to retiree benefits under any other employee pension, or welfare benefit plan.

N. Other Benefits: Other than severance pay, employees shall not be offered, or provided, any other benefits (health, dental, vision, life insurance, or CalPERS/PARS payments). If the employee is being paid by lump sum as described in Section III.H., medical, dental, and vision benefits shall cease on the last day of the month in the same month as the Separation Date, unless otherwise determined by the CEO. All other benefits, including, but not limited to, life insurance and payment towards CalPERS and PARS ends on the Separation Date. If the employee is receiving severance pay through periodic payments as described in Section III.H. above, medical, dental, vision, and other applicable benefits, as determined solely by HR, may cease on the last day of the month in the same month the employee receives his or her last periodic severance payment, unless otherwise determined by the CEO.

O. Time Limits: All time limits herein refer to calendar days. If the expiration of any time limits of this policy falls on a weekend, or a holiday observed by CalOptima, the time limit will be deemed to end on the next workday.

P. Source of Benefits: The benefits provided under this policy shall be unfunded and payable solely from the CalOptima's general fund.

Q. No Individual Liability: It is the express purpose and intention of CalOptima that no individual liability whatsoever shall attach to, or be incurred by, any director, officer, Board Member, executive, employee, representative, or agent of CalOptima. This Policy does not guarantee a right to any employee for severance pay, and such benefit shall be offered at the sole discretion of CalOptima.

R. No Employment References: If an employee terminated as part of the RIF program requests an employment reference from CalOptima, CalOptima shall only provide the employee's date(s) of employment and position in response to such requests. All reference requests must be directed to HR.

S. No Vested Right: This Policy does not guarantee a right to any employee for severance pay, and such benefit, if offered, shall be at the sole discretion of CalOptima.

IV. ATTACHMENT(S)

A. Severance Agreement Under 40
B. Severance Agreement Over 40

V. REFERENCE(S)

A. Age Discrimination in Employment Act, 29 U.S.C. §621 *et seq.*
B. California Labor Code §1400 *et seq.*
C. ~~California SB 1300, Government Code §section~~ 12964.5
~~Older Workers Benefit Protection Act, 29 U.S.C. §§623, 626 & 630~~
~~C.~~D. CalOptima Employee Handbook
~~D.~~E. CalOptima Policy GA.8022: ~~Progressive Discipline~~Performance and Behavior Standards
~~E.~~F. CalOptima Policy GA.8038: Personal Leave of Absence
~~F.~~G. Older Workers Benefit Protection Act, 29 U.S.C. §§623, 626 & 630
~~G.~~H. Worker Adjustment and Retraining Notification Act (WARN), 29 U.S.C. §2101 *et seq.*

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
~~06/04/2015~~08/07/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8047	Reduction In Force	Administrative
Revised	08/07/2014	GA.8047	Reduction In Force	Administrative
Revised	12/01/2016	GA.8047	Reduction In Force	Administrative
Revised	04/05/2018	GA.8047	Reduction In Force	Administrative
Revised	12/03/2020	GA.8047	Reduction In Force	Administrative

IX. GLOSSARY

Term	Definition
Annual Earnings	The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.
At-Will	An employment, having no specified term, may be terminated at the will of employees or employers at any time and with or without cause.
Service	All periods of employment with CalOptima, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima's.
Separation Date	The last day of employment with CalOptima.

Policy:	GA.8047
Title:	**Reduction in Force**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	02/01/2014
Review Date:	12/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines how CalOptima shall administer a Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima to eliminate positions.

II. POLICY

A. All CalOptima employees are At-Will employees. An employee is terminated as part of the RIF program through no fault of his or her own. The RIF is considered an involuntary separation of employment that is intended to be permanent as a result of:

1. Lack of work, changing priorities, budgetary constraints, or other business reasons; or

2. A determination by management that, due to business reasons, an employee's performance, or contribution to the business (although satisfactory), does not meet the needs of the business.

B. As part of the RIF program, CalOptima shall evaluate the business needs of the organization and the need for particular positions. CalOptima shall take into account the relative value of work performed by specific employees, including, but not limited to, performance, qualifications, discipline, attendance, and length of service, so that CalOptima can continue to provide the highest level of service possible with a reduced work force. In implementing an RIF program, CalOptima may consider, depending on the circumstances, various factors, including, but not limited to, the following (which are not presented in any order of importance):

1. CalOptima's need, or lack thereof, for the position occupied by the employee;

2. The contributions which the employee has made to the success of the organization, and the perceived likelihood of contributions to the success of the business in the foreseeable future;

3. Demonstrated high quality performance on the same, or related, assignments;

4. Versatility and ability in applying pertinent skills and experience to current and expected business requirements;

5. The employee's length of service in the particular position to be retained;

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6. The employee's length of service with CalOptima;

7. CalOptima's need to maintain continuity with respect to a particular project or team; and

8. The more recent performance of the employee compared to others in the same classification.

C. In cases where management determines the various factors considered are essentially equal between two (2) or more employees, length of service in the position and/or length of service at CalOptima may be the deciding factor in determining which employee, or employees, shall be retained. In the event an employee who is being laid off has greater length of service in the position and/or length of service at CalOptima than an employee, or employees, being retained within the same classification and specialty in the impacted department, CalOptima must document the basis, in the judgment of management, the employee with less length of service is better suited for retention.

D. The Human Resources Department shall work closely with the Legal Affairs Department to implement the RIF program to ensure compliance with all applicable federal, state, and local laws and regulations.

E. An employee terminated as part of the RIF program must continue to perform his or her duties satisfactorily until the Separation Date. Otherwise, the employee may be subject to disciplinary action, up to and including termination, prior to the specified Separation Date, consistent with CalOptima Policy GA.8022: Performance and Behavior Standards. An employee terminated as a result of failure to perform duties satisfactorily until the Separation Date shall not be qualified to receive any benefits administered as part of the RIF program.

F. Limitations to Eligibility

1. An employee terminated as part of the RIF program will not be eligible to receive benefits under the plan if the employee:

   a. Is terminated for cause, including but not limited to, failure to meet the performance requirements of the position, policy violation, theft, gross misconduct, etc.; or

   b. Fails, or refuses, to return all CalOptima property in the employee's possession, and/or fails to clear all expense and other financial accounts, as of the date of termination. (Examples of CalOptima property include, but are not limited to: CalOptima Security badges, office keys any and all CalOptima documents, files, and computers. Examples of accounts to be cleared include, but are not limited to, the completion and reconciliation of expense accounts); or

   c. Resigns, or otherwise voluntarily terminates, his or her employment; or

   d. Is terminated by temporary layoff, or furlough, except that if CalOptima elects to convert the temporary layoff, or furlough, into a permanent layoff, severance pay may then be payable as of the effective date of permanent layoff, if the employee otherwise is eligible for benefits under the RIF program; or,

   e. Is on a leave of absence, except that if an employee is released to return to work from an approved leave of absence and CalOptima has no assignment for the employee, he/she may be eligible for benefits under the RIF program; or

   f. Is offered a comparable position within CalOptima in lieu of termination, but fails, or refuses, to accept it; or

g. Is terminated because of CalOptima's sale, or transfer, of all, or part, of its assets and his/her employment continues with the agency, or transferee organization, after the transfer has been completed; or

h. Is terminated in connection with the "outsourcing" of operational functions, and he/she is offered comparable employment by the outsourcing vendor. For this purpose, comparable employment shall be defined as a position with substantially the same duties, at the same, or greater, compensation and comparable benefits, which does not require relocation, as defined by the IRS; or

i. Is terminated from employment for failure to return to work following a leave of absence; or

j. Retires; or

k. Is deceased, at which time eligibility for benefits under the RIF program will end and all such benefit payments, if any, will cease; or

l. Is separated from CalOptima because he or she is no longer able to perform the essential functions of his/her job (with or without reasonable accommodation) because of a disability; or

m. Is a temporary employee, intern/volunteer, independent contractor or consultant; or

n. Is an employee employed by CalOptima pursuant to a written contract containing provisions for severance benefits; or

o. Is convicted of a crime involving an abuse of his or her office, or position.

G. This policy sets forth general guidelines to observe in the event of a RIF; however, this policy may be subject to change, deviation, or modification, without notice, depending on the circumstances. Any decision to deviate from this policy in any particular case shall be subject to the discretion of the Chief Executive Officer (CEO).

H. Applicable provisions of this policy may also be used to address employee separations or terminations, other than a RIF, where appropriate, at the discretion of the CEO.

III. PROCEDURE

A. Affected Positions: Following an evaluation of CalOptima's business needs, CalOptima, through appropriate Executive Officers and the Human Resources (HR) Department (hereinafter referred to as the "management"), will identify and determine the positions that will be eliminated and/or affected by a RIF. Management also has the discretion to determine the manner in which the RIF will occur; however, notification to the HR Department should precede the implementation of the RIF.

B. Determinations: Determinations concerning the evaluation of employees, the considerations evaluated, and final recommendations should be made by the employee's immediate supervisor and/or manager with the next higher management level. Documentation of all considerations evaluated should be furnished to HR and approved by management prior to any notification to the employee affected by the RIF.

C. Transfers or Downgrades: Depending on CalOptima's business needs, an employee impacted by the RIF may be offered a downgrade (a lower position and/or reduction in base pay) or lateral transfer (an equivalent position and/or equivalent base pay) to another open job position for which he or she is, in the judgment of management, most qualified even though it is a job position or classification that the employee has not previously held. An employee impacted by the RIF who is offered a lateral transfer, or downgrade, may be provided the option of layoff. HR shall determine, on a case-by-case basis, the time period appropriate to accept, or decline, such job offer.

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G. Release Agreement: In order to be eligible for the severance pay, if offered, an eligible employee must fully complete and execute a Separation Agreement provided by CalOptima, in a form approved by the Legal Affairs Department, at, or near the time of, termination. This Separation Agreement includes a release of all known and unknown claims the employee has, or may have, against CalOptima, as well as an agreement of confidentiality, non-disparagement, and non-solicitation. To be eligible for the severance pay, the Separation Agreement must be signed by the employee and must become irrevocable, in accordance with applicable law.

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payday and will be equal to the amount the employee would have made in wages for the applicable number of weeks of severance pay offered, less applicable taxes and deductions.

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J. Termination of Severance Pay: If a former employee is receiving severance pay through periodic payments as described in Section III.H., severance pay will immediately cease if CalOptima discovers that the employee:

1. Has failed to return all CalOptima property; or

2. Has disclosed or used confidential information about CalOptima for the benefit of a third party; or

3. Has defamed CalOptima; or

4. Has been hired on a full-time basis by another employer; or

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K. Death: If a former employee dies before all payments have been made, severance payments will cease. No benefits will continue to a beneficiary.

L. Returning to Work: If an employee is eligible for and receives benefits under this Policy, and that employee later returns to work for CalOptima before receiving all payments under this Policy, further severance payments will cease effective on the rehire date. If the employee later becomes eligible for benefits under this Policy, the subsequent severance payment calculated based on the total years of service will be reduced by the amount of severance payments previously paid.

M. Retirement Benefits: The receipt of severance pay under this Policy shall have no effect on the employee's right, if any, to retiree benefits under any other employee pension, or welfare benefit plan.

N. Other Benefits: Other than severance pay, employees shall not be offered, or provided, any other benefits (health, dental, vision, life insurance, or CalPERS/PARS payments). If the employee is being paid by lump sum as described in Section III.H., medical, dental, and vision benefits shall cease on the last day of the month in the same month as the Separation Date, unless otherwise determined by the CEO. All other benefits, including, but not limited to, life insurance and payment towards CalPERS and PARS ends on the Separation Date. If the employee is receiving severance pay through periodic payments as described in Section III.H. above, medical, dental, vision, and other applicable benefits, as determined solely by HR, may cease on the last day of the month in the same month the employee receives his or her last periodic severance payment, unless otherwise determined by the CEO.

O. Time Limits: All time limits herein refer to calendar days. If the expiration of any time limits of this policy falls on a weekend, or a holiday observed by CalOptima, the time limit will be deemed to end on the next workday.

P. Source of Benefits: The benefits provided under this policy shall be unfunded and payable solely from the CalOptima's general fund.

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R. No Employment References: If an employee terminated as part of the RIF program requests an employment reference from CalOptima, CalOptima shall only provide the employee's date(s) of employment and position in response to such requests. All reference requests must be directed to HR.

S. No Vested Right: This Policy does not guarantee a right to any employee for severance pay, and such benefit, if offered, shall be at the sole discretion of CalOptima.

IV. ATTACHMENT(S)

A. Severance Agreement Under 40
B. Severance Agreement Over 40

V. REFERENCE(S)

A. Age Discrimination in Employment Act, 29 U.S.C. §621 *et seq.*
B. California Labor Code §1400 *et seq.*
C. Government Code §12964.5
D. CalOptima Employee Handbook
E. CalOptima Policy GA.8022: Performance and Behavior Standards
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G. Older Workers Benefit Protection Act, 29 U.S.C. §§623, 626 & 630
H. Worker Adjustment and Retraining Notification Act (WARN), 29 U.S.C. §2101 *et seq.*

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
12/01/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8047	Reduction In Force	Administrative
Revised	08/07/2014	GA.8047	Reduction In Force	Administrative
Revised	12/01/2016	GA.8047	Reduction In Force	Administrative
Revised	04/05/2018	GA.8047	Reduction In Force	Administrative
Revised	12/03/2020	GA.8047	Reduction In Force	Administrative

IX. GLOSSARY

Term	Definition
Annual Earnings	The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.
At-Will	An employment, having no specified term, may be terminated at the will of employees or employers at any time and with or without cause.
Service	All periods of employment with CalOptima, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima's.
Separation Date	The last day of employment with CalOptima.

SEPARATION AGREEMENT AND GENERAL RELEASE

By signing this ~~Settlement~~ Separation Agreement and General Release ("Agreement"), I,_____ – _____ ("Employee") acknowledge that CalOptima (hereinafter referred to as "Employer") and I have reached a final and binding agreement concerning my separation from employment with Employer. Specifically, I acknowledge that we have agreed on the following terms and that this document contains our entire agreement.

NOW THEREFORE, for good and sufficient consideration, as set forth below, the parties agree as follows:

AGREEMENT

1. ~~1.~~ Separation Date. Employee's last day of work will be mm,dd,yyyy ("Separation Date").

2. ~~2.~~ Consideration To Employee. Employee shall be entitled to the following:

   A. ~~A.~~ Employee shall receive his/her regular pay through Separation Date to the extent any is due. Employee will receive a check for all unused Paid Time Off (PTO) and Flex Holiday time, less deductions required by law, accrued by Employee through the Separation Date. All payments will be made consistent with CalOptima's payroll schedule.

   B. ~~B.~~ If, and only if, Employee signs this Agreement and complies with its terms, and after expiration of the seven (7) day revocation period set forth in Paragraph 18 of this Agreement, Employee shall receive severance pay in [biweekly installments of $$$$$, less deductions required by law and less deductions for medical, dental and vision coverage and/or other benefits where applicable, from the Separation Date through mm,dd,yyyy] OR [a lump sum payment of $$$$$, which reflects XX weeks of severance pay, less deductions required by law and less deductions for medical, dental and vision where applicable] (the Severance Period). [Add the following when employee receives biweekly installments ONLY: As a condition of receiving biweekly installments, Employee shall be required to remain reasonably available during the time period Employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters.]

   C. ~~C.~~ Employer shall make payments (Employer share only) on behalf of Employee for medical, dental and vision coverage through mm,dd,yyyy. Employee shall be responsible for the Employee share of premiums. All other benefits shall cease on [the Separation Date] OR [at the end of the Severance Period].

D. ~~D.~~ Employer will not challenge any applications by Employee for unemployment insurance compensation.

E. ~~E.~~ Employee will receive optional outplacement services through a designated outplacement firm for a period not to exceed thirty (30) calendar ~~business~~ days.

3. ~~3.~~ Acknowledgement. Employee acknowledges that Employee has reviewed the consideration specified above. Employee agrees that the consideration set forth above represents a complete and final settlement of any and all claims Employee has had, now has or may have up to the effective date of this Agreement, including, without limitation, claims arising out of or in connection with Employee's employment and/or termination by CalOptima. Employee acknowledges Employer does not owe Employee any additional wages, commissions, bonuses, PTO pay, severance pay, overtime pay, retirement pay, holiday pay, incentives or other compensation, benefits or payments of any kind or nature, other than that specifically stated in this Agreement.

4. ~~4.~~ Specific Release. In exchange for the receipt of the foregoing consideration, Employee expressly releases and discharges Employer, Employer's board members, officers, directors, agents, past and present employees, representatives, attorneys, insurers and re-insurers, successors, and assigns, and each of them, and all persons and/or entities acting by, through, under, or in concert with such persons (collectively, the "Employer Releasees") from any and all actual or potential claims or causes of action, including but not limited to claims for back pay, emotional distress, attorneys' fees and costs related to pre-litigation or litigation, obligations, demands, and causes of action, known or unknown, which Employee has had, now has, or may have against the Employer Releasees up to the effective date of this Agreement, including, without limitation, claims based upon:

A. Title VII of the Civil Rights Act of 1964;

B. The Americans with Disabilities Act (ADA);

C. The Equal Pay Act (EPA);

D. California statutory, regulatory or decisional law, including the ~~State~~ California Fair Employment and Housing Act, pertaining to employment discrimination, failure to prevent discrimination, harassment, retaliation, failure to engage in the interactive process or failure to provide reasonable accommodation, wrongful termination or breach of public policy, or wrongful discharge, transfer, or demotion;

E. ~~.~~ Any and all State, Federal and local laws as well as common law for claims of breach of implied or express contract, negligent or intentional infliction of emotional distress, defamation, fraud, concealment, false promise, negligent misrepresentation, intentional interference with contractual relations, breach of the

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covenant of good faith and fair dealing, wrongful termination in violation of public policy, and constructive discharge;

F. ~~F.~~ California Labor Code provisions pertaining to whistleblower rights and other benefits and protections set forth therein;

~~F.~~G. Violation of due process rights; and

H~~G.~~ ~~.~~ Any and all claims arising from the California Labor Code or the Fair Labor Standards Act.

5. General Release. Employee, on behalf of himself/herself and his/her executors, heirs or assigns, hereby releases and discharges Employer Releasees from any and all actual or potential claims, obligations, and causes of action, known or unknown, which Employee has, may have, or may claim to have up to the effective date of this Agreement against Employer Releasees, without limitation, such claims arising out of or in connection with Employee's employment with, and/or separation from the Employer. Employee acknowledges that he or she may have claims that are covered by the terms of this Agreement herein which have not yet been discovered.

Nevertheless, Employee ~~expressly~~ hereby waives and relinquishes all rights and benefits under Section 1542 of the California Civil Code, which states:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

Employee acknowledges that Employee has read and understands the Employee's rights under Section 1542 of the California Civil Code above, and by signing below, Employee voluntarily waives all known and unknown claims existing on or prior to the effective date of this Agreement.

6. ~~6.~~ Claims Arising After the Effective Date. This Agreement does not apply to rights or claims that may arise after the effective date of this Agreement.

7. ~~7.~~ No Pending Action. Employer and Employee hereby agree that as of the effective date of this Agreement, no action, suit or proceeding has been or shall be brought or complaint filed or initiated by Employer or Employee or any agent, assign or spouse of either in any court, or with any governmental body. This includes any matter or cause of action based upon any facts that might have occurred prior to the effective date of this Agreement whether known to either party now or discovered by either party hereafter.

8. ~~8.~~ No Admission of Liability. Employer and Employee agree that this Agreement and the payment by Employer of the consideration described herein is not an admission by Employer, Employer Releasees or Employee of any wrongdoing or liability. All parties specifically deny any liability; wrongful acts; violations of any federal, state, or local law, regulation, order, or other requirement of law; breach of contract (actual or implied); or any other civil wrong. The parties have entered into this Agreement in order to settle all disputes and differences between them, without admitting liability or wrongdoing by any party.

9. ~~9.~~ Confidentiality. This Agreement shall remain confidential as a personnel record to the extent permissible by Government Code Section 6254(c). In the event a Public Records Act request is made to review and/or copy this Agreement, Employer's only obligation shall be to timely notify Employee of that request. Employer shall not be obligated to incur legal expenses to deny such a request.

10. ~~10.~~ References. If Employee requests an employment reference from Employer, Employer shall only provide the Employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Employer's Human Resources Department.

11. ~~11.~~ Non-Disparagement. Employer and Employee each warrant and agree that he/she/it will not disseminate, orally or in writing, any comments which are in any way negative about, or disparaging to the other, or to the other's representatives or Employees, individually or collectively.

12. ~~12.~~ Employer Property. On Employee's Separation Date, Employee agrees to return all Employer property, including, but not limited to: keys; key cards; equipment and supplies; electronic and physical documents and files; and all confidential, private, and proprietary documents and files. Employee also agrees to continue to comply with CalOptima Policy GA 8050: Confidentiality, which is incorporated into this Agreement herein by reference, even after the Separation Date.

13. ~~13.~~ Construction. This Agreement has been negotiated and discussed between the parties and it reflects their mutual agreement regarding the subject matter of this Agreement. Neither party shall be deemed to be the drafter of this Agreement. Therefore, no presumption for or against the drafter shall be applicable in interpreting or enforcing this Agreement.

14. ~~14.~~ Separability. If any provision of this Agreement, or the application thereof to any person or circumstance, is found to be invalid, the remainder of the provisions of this Agreement, or the application of such provisions to persons or circumstances other than those which it is found to be invalid, as the case may be, shall not be affected.

15. ~~15.~~ Advice of Counsel. Employer has advised Employee to consult with a private attorney prior to executing this Agreement. Employee fully understands the right to discuss all aspects of this Agreement with a private attorney and has had reasonable and

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sufficient time and opportunity to consult with an attorney. Employee has either consulted with an attorney of his or her own choosing or has elected to enter into this Agreement without consultation with an attorney despite Employer's advice to consult with an attorney. ~~read~~ ~~do so~~. Employee has had sufficient time to read and consider the terms of this Agreement, fully understands all of the provisions of this Agreement and is freely and voluntarily entering into this Agreement.

16. ~~16.~~ Complete Agreement. This is the entire agreement between Employer and Employee with respect to the subject matter herein and this Agreement supersedes all prior and contemporaneous oral and written agreements and discussions.

17. ~~17.~~ Acknowledgment of Days to Consider. Employee has been advised of the right to consider this Agreement for up to twenty-one (21) calendar days prior to its execution and has either: (a) been provided the full period to consider the agreement; or (b) voluntarily waived the full period, electing with full knowledge and consent to execute this Agreement as of the date indicated on the signature line of this Agreement.

18. ~~18.~~ Revocation. Employee may revoke this Agreement for a period of seven (7) calendar days following its execution. Said revocation must be in writing, must specifically revoke this Agreement, and must be received by the Executive Director of Human Resources, at Employer's premises, prior to the end of the seventh day following Employee's execution. Upon expiration of the seven (7) calendar day period, this Agreement becomes effective, enforceable and irrevocable. If Employee has not delivered written revocation of this Agreement to Employer within said seven (7) calendar day period, Employee will receive the consideration described in paragraph 2 above.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, Employee acknowledges that Employee has been advised to **CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT AND GENERAL RELEASE**, and Employee understands that by signing this Agreement and General Release, Employee is giving up and waiving important legal rights. Nevertheless, Employee and Employer mutually agree to the terms above, and hereby execute this Agreement on the day and year last shown below.

~~Date:~~ _____ _____

"EMPLOYER"

Date: _____ _____

_____

By: Richard Sanchez~~Michael Schrader~~

Its: Chief Executive Officer

~~Date:~~ _____

"EMPLOYEE"

Date: _____ _____

_____

By:_____

(print name)

SEPARATION AGREEMENT AND GENERAL RELEASE

By signing this Separation Agreement and General Release ("Agreement"), I,_____ ("Employee") acknowledge that CalOptima (hereinafter referred to as "Employer") and I have reached a final and binding agreement concerning my separation from employment with Employer. Specifically, I acknowledge that we have agreed on the following terms and that this document contains our entire agreement.

NOW THEREFORE, for good and sufficient consideration, as set forth below, the parties agree as follows:

AGREEMENT

1. Separation Date. Employee's last day of work will be mm,dd,yyyy ("Separation Date").

2. Consideration To Employee. Employee shall be entitled to the following:

   A. Employee shall receive his/her regular pay through Separation Date to the extent any is due. Employee will receive a check for all unused Paid Time Off (PTO) and Flex Holiday time, less deductions required by law, accrued by Employee through the Separation Date. All payments will be made consistent with CalOptima's payroll schedule.

   B. If, and only if, Employee signs this Agreement and complies with its terms, and after expiration of the seven (7) day revocation period set forth in Paragraph 18 of this Agreement, Employee shall receive severance pay in [biweekly installments of $$$$$, less deductions required by law and less deductions for medical, dental and vision coverage and/or other benefits where applicable, from the Separation Date through mm,dd,yyyy] OR [a lump sum payment of $$$$$, which reflects XX weeks of severance pay, less deductions required by law and less deductions for medical, dental and vision where applicable] (the Severance Period). [Add the following when employee receives biweekly installments ONLY: As a condition of receiving biweekly installments, Employee shall be required to remain reasonably available during the time period Employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters.]

   C. Employer shall make payments (Employer share only) on behalf of Employee for medical, dental and vision coverage through mm,dd,yyyy. Employee shall be responsible for the Employee share of premiums. All other benefits shall cease on [the Separation Date] OR [at the end of the Severance Period].

D. Employer will not challenge any applications by Employee for unemployment insurance compensation.

E. Employee will receive optional outplacement services through a designated outplacement firm for a period not to exceed thirty (30) calendar days.

3. Acknowledgement. Employee acknowledges that Employee has reviewed the consideration specified above. Employee agrees that the consideration set forth above represents a complete and final settlement of any and all claims Employee has had, now has or may have up to the effective date of this Agreement, including, without limitation, claims arising out of or in connection with Employee's employment and/or termination by CalOptima. Employee acknowledges Employer does not owe Employee any additional wages, commissions, bonuses, PTO pay, severance pay, overtime pay, retirement pay, holiday pay, incentives or other compensation, benefits or payments of any kind or nature, other than that specifically stated in this Agreement.

4. Specific Release. In exchange for the receipt of the foregoing consideration, Employee expressly releases and discharges Employer, Employer's board members, officers, directors, agents, past and present employees, representatives, attorneys, insurers and re-insurers, successors, and assigns, and each of them, and all persons and/or entities acting by, through, under, or in concert with such persons (collectively, the "Employer Releasees") from any and all actual or potential claims or causes of action, including but not limited to claims for back pay, emotional distress, attorneys' fees and costs related to pre-litigation or litigation, obligations, demands, and causes of action, known or unknown, which Employee has had, now has, or may have against the Employer Releasees up to the effective date of this Agreement, including, without limitation, claims based upon:

A. Title VII of the Civil Rights Act of 1964;

B. The Americans with Disabilities Act (ADA);

C. The Equal Pay Act (EPA);

D. California statutory, regulatory or decisional law, including the California Fair Employment and Housing Act, pertaining to employment discrimination, failure to prevent discrimination, harassment, retaliation, failure to engage in the interactive process or failure to provide reasonable accommodation, wrongful termination or breach of public policy, or wrongful discharge, transfer, or demotion;

E. Any and all State, Federal and local laws as well as common law for claims of breach of implied or express contract, negligent or intentional infliction of emotional distress, defamation, fraud, concealment, false promise, negligent misrepresentation, intentional interference with contractual relations, breach of the covenant of good faith and fair dealing, wrongful termination in violation of public policy, and constructive discharge;

F. California Labor Code provisions pertaining to whistleblower rights and other benefits and protections set forth therein;

G. Violation of due process rights; and

H. Any and all claims arising from the California Labor Code or the Fair Labor Standards Act.

5. General Release. Employee, on behalf of himself/herself and his/her executors, heirs or assigns, hereby releases and discharges Employer Releasees from any and all actual or potential claims, obligations, and causes of action, known or unknown, which Employee has, may have, or may claim to have up to the effective date of this Agreement against Employer Releasees, without limitation, such claims arising out of or in connection with Employee's employment with, and/or separation from the Employer. Employee acknowledges that he or she may have claims that are covered by the terms of this Agreement herein which have not yet been discovered.

Nevertheless, Employee hereby waives and relinquishes all rights and benefits under Section 1542 of the California Civil Code, which states:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

Employee acknowledges that Employee has read and understands the Employee's rights under Section 1542 of the California Civil Code above, and by signing below, Employee voluntarily waives all known and unknown claims existing on or prior to the effective date of this Agreement.

6. Claims Arising After the Effective Date. This Agreement does not apply to rights or claims that may arise after the effective date of this Agreement.

7. No Pending Action. Employer and Employee hereby agree that as of the effective date of this Agreement, no action, suit or proceeding has been or shall be brought or complaint filed or initiated by Employer or Employee or any agent, assign or spouse of either in any court, or with any governmental body. This includes any matter or cause of action based upon any facts that might have occurred prior to the effective date of this Agreement whether known to either party now or discovered by either party hereafter.

8. No Admission of Liability. Employer and Employee agree that this Agreement and the payment by Employer of the consideration described herein is not an admission by

Employer, Employer Releasees or Employee of any wrongdoing or liability. All parties specifically deny any liability; wrongful acts; violations of any federal, state, or local law, regulation, order, or other requirement of law; breach of contract (actual or implied); or any other civil wrong. The parties have entered into this Agreement in order to settle all disputes and differences between them, without admitting liability or wrongdoing by any party.

9. Confidentiality. This Agreement shall remain confidential as a personnel record to the extent permissible by Government Code Section 6254(c). In the event a Public Records Act request is made to review and/or copy this Agreement, Employer's only obligation shall be to timely notify Employee of that request. Employer shall not be obligated to incur legal expenses to deny such a request.

10. References. If Employee requests an employment reference from Employer, Employer shall only provide the Employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Employer's Human Resources Department.

11. Non-Disparagement. Employer and Employee each warrant and agree that he/she/it will not disseminate, orally or in writing, any comments which are in any way negative about, or disparaging to the other, or to the other's representatives or Employees, individually or collectively.

12. Employer Property. On Employee's Separation Date, Employee agrees to return all Employer property, including, but not limited to: keys; key cards; equipment and supplies; electronic and physical documents and files; and all confidential, private, and proprietary documents and files. Employee also agrees to continue to comply with CalOptima Policy GA 8050: Confidentiality, which is incorporated into this Agreement herein by reference, even after the Separation Date.

13. Construction. This Agreement has been negotiated and discussed between the parties and it reflects their mutual agreement regarding the subject matter of this Agreement. Neither party shall be deemed to be the drafter of this Agreement. Therefore, no presumption for or against the drafter shall be applicable in interpreting or enforcing this Agreement.

14. Separability. If any provision of this Agreement, or the application thereof to any person or circumstance, is found to be invalid, the remainder of the provisions of this Agreement, or the application of such provisions to persons or circumstances other than those which it is found to be invalid, as the case may be, shall not be affected.

15. Advice of Counsel. Employer has advised Employee to consult with a private attorney prior to executing this Agreement. Employee fully understands the right to discuss all aspects of this Agreement with a private attorney and has had reasonable and sufficient time and opportunity to consult with an attorney. Employee has either consulted with an attorney of his or her own choosing or has elected to enter into this Agreement

without consultation with an attorney despite Employer's advice to consult with an attorney. . Employee has had sufficient time to read and consider the terms of this Agreement, fully understands all of the provisions of this Agreement and is freely and voluntarily entering into this Agreement.

16. Complete Agreement. This is the entire agreement between Employer and Employee with respect to the subject matter herein and this Agreement supersedes all prior and contemporaneous oral and written agreements and discussions.

17. Acknowledgment of Days to Consider. Employee has been advised of the right to consider this Agreement for up to twenty-one (21) calendar days prior to its execution and has either: (a) been provided the full period to consider the agreement; or (b) voluntarily waived the full period, electing with full knowledge and consent to execute this Agreement as of the date indicated on the signature line of this Agreement.

18. Revocation. Employee may revoke this Agreement for a period of seven (7) calendar days following its execution. Said revocation must be in writing, must specifically revoke this Agreement, and must be received by the Executive Director of Human Resources, at Employer's premises, prior to the end of the seventh day following Employee's execution. Upon expiration of the seven (7) calendar day period, this Agreement becomes effective, enforceable and irrevocable. If Employee has not delivered written revocation of this Agreement to Employer within said seven (7) calendar day period, Employee will receive the consideration described in paragraph 2 above.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, Employee acknowledges that Employee has been advised to **CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT AND GENERAL RELEASE**, and Employee understands that by signing this Agreement and General Release, Employee is giving up and waiving important legal rights. Nevertheless, Employee and Employer mutually agree to the terms above, and hereby execute this Agreement on the day and year last shown below.

"EMPLOYER"

Date: _____ _____

By: Richard Sanchez
Its: Chief Executive Officer

"EMPLOYEE"

Date: _____ _____

By:_____
(print name)

SEPARATION AGREEMENT AND GENERAL RELEASE

By signing this ~~Settlement~~Separation Agreement and General Release ("Agreement"), I, _____ ("Employee") acknowledge that CalOptima (hereinafter referred to as "Employer") and I have reached a final and binding agreement concerning my separation from employment with Employer. Specifically, I acknowledge that we have agreed on the following terms and that this document contains our entire agreement.

NOW THEREFORE, for good and sufficient consideration, as set forth below, the parties agree as follows:

AGREEMENT

1. ~~1.~~ Separation Date. Employee's last day of work will be mm,dd,yyyy ("Separation Date").

2. ~~2.~~ Consideration To Employee. Employee shall be entitled to the following:

   A. ~~A.~~ Employee shall receive his/her regular pay through Separation Date to the extent any is due. Employee will receive a check for all unused Paid Time Off (PTO) and Flex Holiday time, less deductions required by law, accrued by Employee through the Separation Date. All payments will be made consistent with CalOptima's payroll schedule.

   B. ~~B.~~ If, and only if, Employee signs this Agreement and complies with its terms, and after expiration of the seven (7) day revocation period set forth in Paragraph 19 of this Agreement, Employee shall receive severance pay in [biweekly installments of ~~$$$$$,~~$$$$, less deductions required by law and less deductions for medical, dental and vision coverage and/or other benefits where applicable, from the Separation Date through mm,dd,yyyy] OR [a lump sum payment of $$$$$, which reflects XX weeks of severance pay, less deductions required by law and less deductions for medical, dental and vision where applicable] (the Severance Period). ~~-~~[Add the following when employee receives biweekly installments ONLY: As a condition of receiving biweekly installments, Employee shall be required to remain reasonably available during the time period Employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters.]

   C. ~~C.~~ Employer shall make payments (Employer share only) on behalf of Employee for medical, dental and vision coverage through mm,dd,yyyy. ~~-~~Employee shall be responsible for the Employee share of premiums. All other benefits shall cease on [the Separation Date] OR [at the end of the Severance Period].

   D. ~~D.~~ Employer will not challenge any applications by Employee for unemployment insurance compensation.

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E. ~~E.~~ Employee will receive optional outplacement services through a designated outplacement firm for a period not to exceed thirty (30) calendar ~~business~~ days.

3. ~~3.~~ Acknowledgement. ~~-~~Employee acknowledges that Employee has reviewed the consideration specified above. Employee agrees that the consideration set forth above represents a complete and final settlement of any and all claims Employee has had, now has or may have up to the effective date of this Agreement, including, without limitation, claims arising out of or in connection with Employee's employment and/or termination by CalOptima. Employee acknowledges Employer does not owe Employee any additional wages, commissions, bonuses, PTO pay, severance pay, overtime pay, retirement pay, holiday pay, incentives or other compensation, benefits or payments of any kind or nature, other than that specifically stated in this Agreement.

4. ~~4.~~ Specific Release. In exchange for the receipt of the foregoing consideration, Employee expressly releases and discharges Employer, Employer's board members, officers, directors, agents, past and present employees, representatives, attorneys, insurers and re-insurers, successors, and assigns, and each of them, and all persons and/or entities acting by, through, under, or in concert with such persons (collectively, the "Employer Releasees") from any and all actual or potential claims or causes of action, including but not limited to claims for back pay, emotional distress, attorneys' fees and costs related to pre-litigation or litigation, obligations, demands, and causes of action, known or unknown, which Employee has had, now has, or may have against the Employer Releasees up to the effective date of this Agreement, including, without limitation, claims based upon:

A. Title VII of the Civil Rights Act of 1964;

B. The Age Discrimination in Employment Act (ADEA) (as amended by the Older Workers Benefit Protection Act (OWBPA));

C. The Americans with Disabilities Act (ADA);

D. The Equal Pay Act (EPA);

E. ~~D.~~ California statutory, regulatory, or decisional case law, including the ~~State~~ California Fair Employment and Housing Act, pertaining to employment discrimination, failure to prevent discrimination, harassment, retaliation, failure to engage in the interactive process or failure to provide reasonable accommodation,

wrongful termination or breach of public policy, or wrongful discharge, transfer, or demotion;

F. ~~EF.~~ Any and all State, Federal and local laws as well as common law for claims of breach of implied or express contract, negligent or intentional infliction of emotional distress, defamation, fraud, concealment, false promise, negligent misrepresentation, intentional interference with contractual relations, breach of the covenant of good faith and fair dealing, wrongful termination in violation of public policy, and constructive discharge; ~~and~~

G. ~~FG.~~ California Labor Code provisions pertaining to whistleblower rights and other benefits and protections set forth therein; ~~and~~

~~G.~~H. Violation of due process rights; and

~~H.~~I. ~~GH.~~ Any and all claims arising from the California Labor Code or the Fair Labor Standards Act.

5. ~~5.~~ General Release.~~:~~ Employee, on behalf of himself/herself and his/her executors, heirs or assigns, hereby releases and discharges Employer Releasees from any and all actual or potential claims, obligations, and causes of action, known or unknown, which Employee has, may have, or may claim to have up to the effective date of this Agreement against Employer Releasees, without limitation, such claims arising out of or in connection with Employee's employment with, and/or separation from the Employer. Employee acknowledges that he or she may have claims that are covered by the terms of this Agreement herein which have not yet been discovered.

Nevertheless, Employee hereby ~~expressly~~ waives and relinquishes all rights and benefits under Section 1542 of the California Civil Code~~,~~ which states:

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Employee acknowledges that Employee has read and understands the Employee's rights under Section 1542 of the California Civil Code above, and by signing below, Employee voluntarily waives all known and unknown claims existing on or prior to the effective date of this Agreement.

6. ~~6.~~ Claims Arising After the Effective Date. This Agreement does not apply to rights or claims that may arise after the effective date of this Agreement.

7. ~~7.~~ No Pending Action. Employer and Employee hereby agree that as of the effective date of this Agreement, no action, suit or proceeding has been or shall be brought or complaint filed or initiated by Employer or Employee or any agent, assign or spouse of either in any court, or with any governmental body. This includes any matter or cause of action based upon any facts that might have occurred prior to the effective date of this Agreement whether known to either party now or discovered by either party hereafter.

8. ~~8.~~ No Admission of Liability. Employer and Employee agree that this Agreement and the payment by Employer of the consideration described herein is not an admission by Employer, Employer Releasees or Employee of any wrongdoing or liability. All parties specifically deny any liability; wrongful acts; violations of any federal, state, or local law, regulation, order, or other requirement of law; breach of contract (actual or implied); or any other civil wrong. The parties have entered into this Agreement in order to settle all disputes and differences between them, without admitting liability or wrongdoing by any party.

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14. ~~14.~~ Separability. If any provision of this Agreement, or the application thereof to any person or circumstance, is found to be invalid, the remainder of the provisions of this Agreement, or the application of such provisions to persons or circumstances other than those which it is found to be invalid, as the case may be, shall not be affected.

15. ~~15.~~ Advice of Counsel. Employer has advised Employee to consult with a private attorney prior to executing this Agreement. Employee fully understands the right to discuss all aspects of this Agreement with a private attorney and has had reasonable and sufficient time and opportunity to consult with an attorney. Employee has either consulted with an attorney of his or her own ~~choosing, or~~choosing or has elected to enter into this Agreement without consultation with an attorney despite ~~Employers~~Employer's advice to ~~do so.~~consult with an attorney. Employee has had sufficient time to read and consider the terms of this Agreement, fully understands all of the provisions of this Agreement and is freely and voluntarily entering into this Agreement.

16. ~~16.~~ Complete Agreement. This is the entire agreement between Employer and Employee with respect to the subject matter herein and this Agreement supersedes all prior and contemporaneous oral and written agreements and discussions.

17. ~~17.~~ Acknowledgment of Days to Consider. Employee has been advised of the right to consider this Agreement for up to twenty-one (21) calendar days prior to its execution and has either: (a) been provided the full period to consider the agreement; or (b) voluntarily waived the full period, electing with full knowledge and consent to execute this Agreement as of the date indicated on the signature line of this Agreement.

18. ~~18.18.~~ [USE ONLY ~~F~~for RIF of 2 or more employees] Summary of Considerations. The classification, department, or group of individuals covered by CalOptima's reduction in force (RIF) includes all employees in the [describe impacted location, area, department, line of business, etc., (e.g. ~~caloptima~~CalOptima, Human Resources, PACE, O~~o~~neC~~c~~are, etc.)] whose employment is being terminated in the RIF during the following period (XX/XX/XXXX to XX/XX/XXXX). All employees in [describe impacted location, area, department, line of business, etc., (e.g. CalOptima~~PTIMA~~, PACE, One~~NE~~Care~~ARE~~, etc.)] whose employment is being terminated are eligible for the RIF.

The following is a listing of the ages and job titles of employees who were and were not selected for layoff [or termination] and offered consideration for signing the waiver. Except for those employees selected for layoff [or termination], no other employee is eligible or offered consideration in exchange for signing the waiver:

Job Title	Department/Unit	Age	# Selected	# Not Selected

19. ~~19.~~ Revocation. Employee may revoke this Agreement for a period of seven (7) calendar days following its execution. Said revocation must be in writing, must specifically revoke this Agreement, and must be received by the Executive Director of Human Resources, at Employer's premises, prior to the end of the seventh day following Employee's execution. Upon expiration of the seven (7) calendar day period, this Agreement becomes effective, enforceable and irrevocable. If Employee has not delivered written revocation of this Agreement to Employer within said seven (7) calendar day period, Employee will receive the consideration described in paragraph 2 above.

[SIGNATURES ON FOLLOWING PAGE]

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IN WITNESS THEREOF, Employee acknowledges that Employee has been advised to **CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT AND GENERAL RELEASE**, and Employee understands that by signing this Agreement and General Release, Employee is giving up and waiving important legal rights. Nevertheless, Employee and Employer mutually agree to the terms above, and hereby execute this Agreement on the day and year last shown below.

~~Date:~~ _____ _____

"EMPLOYER"

Date: _____ _____

_____

By: ~~Michael Schrader~~Richard Sanchez
Its: Chief Executive Officer

~~Date:~~ _____ _____

"EMPLOYEE"

Date: _____ _____

_____

By:_____
(print name)

SEPARATION AGREEMENT AND GENERAL RELEASE

By signing this Separation Agreement and General Release ("Agreement"), I, _____ ("Employee") acknowledge that CalOptima (hereinafter referred to as "Employer") and I have reached a final and binding agreement concerning my separation from employment with Employer. Specifically, I acknowledge that we have agreed on the following terms and that this document contains our entire agreement.

NOW THEREFORE, for good and sufficient consideration, as set forth below, the parties agree as follows:

AGREEMENT

1. Separation Date. Employee's last day of work will be mm,dd,yyyy ("Separation Date").

2. Consideration To Employee. Employee shall be entitled to the following:

   A. Employee shall receive his/her regular pay through Separation Date to the extent any is due. Employee will receive a check for all unused Paid Time Off (PTO) and Flex Holiday time, less deductions required by law, accrued by Employee through the Separation Date. All payments will be made consistent with CalOptima's payroll schedule.

   B. If, and only if, Employee signs this Agreement and complies with its terms, and after expiration of the seven (7) day revocation period set forth in Paragraph 19 of this Agreement, Employee shall receive severance pay in [biweekly installments of $$$$, less deductions required by law and less deductions for medical, dental and vision coverage and/or other benefits where applicable, from the Separation Date through mm,dd,yyyy] OR [a lump sum payment of $$$$$, which reflects XX weeks of severance pay, less deductions required by law and less deductions for medical, dental and vision where applicable] (the Severance Period). [Add the following when employee receives biweekly installments ONLY: As a condition of receiving biweekly installments, Employee shall be required to remain reasonably available during the time period Employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters.]

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   D. Employer will not challenge any applications by Employee for unemployment insurance compensation.

E. Employee will receive optional outplacement services through a designated outplacement firm for a period not to exceed thirty (30) calendar days.

3. Acknowledgement. Employee acknowledges that Employee has reviewed the consideration specified above. Employee agrees that the consideration set forth above represents a complete and final settlement of any and all claims Employee has had, now has or may have up to the effective date of this Agreement, including, without limitation, claims arising out of or in connection with Employee's employment and/or termination by CalOptima. Employee acknowledges Employer does not owe Employee any additional wages, commissions, bonuses, PTO pay, severance pay, overtime pay, retirement pay, holiday pay, incentives or other compensation, benefits or payments of any kind or nature, other than that specifically stated in this Agreement.

4. Specific Release. In exchange for the receipt of the foregoing consideration, Employee expressly releases and discharges Employer, Employer's board members, officers, directors, agents, past and present employees, representatives, attorneys, insurers and re-insurers, successors, and assigns, and each of them, and all persons and/or entities acting by, through, under, or in concert with such persons (collectively, the "Employer Releasees") from any and all actual or potential claims or causes of action, including but not limited to claims for back pay, emotional distress, attorneys' fees and costs related to pre-litigation or litigation, obligations, demands, and causes of action, known or unknown, which Employee has had, now has, or may have against the Employer Releasees up to the effective date of this Agreement, including, without limitation, claims based upon:

A. Title VII of the Civil Rights Act of 1964;

B. The Age Discrimination in Employment Act (ADEA) (as amended by the Older Workers Benefit Protection Act (OWBPA));

C. The Americans with Disabilities Act (ADA);

D. The Equal Pay Act (EPA);

E. California statutory, regulatory, or decisional case law, including the California Fair Employment and Housing Act, pertaining to employment discrimination, failure to prevent discrimination, harassment, retaliation, failure to engage in the interactive process or failure to provide reasonable accommodation, wrongful termination or breach of public policy, or wrongful discharge, transfer, or demotion;

F. Any and all State, Federal and local laws as well as common law for claims of breach of implied or express contract, negligent or intentional infliction of emotional distress, defamation, fraud, concealment, false promise, negligent misrepresentation, intentional interference with contractual relations, breach of the

covenant of good faith and fair dealing, wrongful termination in violation of public policy, and constructive discharge;

G. California Labor Code provisions pertaining to whistleblower rights and other benefits and protections set forth therein;

H. Violation of due process rights; and

I. Any and all claims arising from the California Labor Code or the Fair Labor Standards Act.

5. General Release. Employee, on behalf of himself/herself and his/her executors, heirs or assigns, hereby releases and discharges Employer Releasees from any and all actual or potential claims, obligations, and causes of action, known or unknown, which Employee has, may have, or may claim to have up to the effective date of this Agreement against Employer Releasees, without limitation, such claims arising out of or in connection with Employee's employment with, and/or separation from the Employer. Employee acknowledges that he or she may have claims that are covered by the terms of this Agreement herein which have not yet been discovered.

Nevertheless, Employee hereby waives and relinquishes all rights and benefits under Section 1542 of the California Civil Code which states:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

Employee acknowledges that Employee has read and understands the Employee's rights under Section 1542 of the California Civil Code above, and by signing below, Employee voluntarily waives all known and unknown claims existing on or prior to the effective date of this Agreement.

6. Claims Arising After the Effective Date. This Agreement does not apply to rights or claims that may arise after the effective date of this Agreement.

7. No Pending Action. Employer and Employee hereby agree that as of the effective date of this Agreement, no action, suit or proceeding has been or shall be brought or complaint filed or initiated by Employer or Employee or any agent, assign or spouse of either in any court, or with any governmental body. This includes any matter or cause of action based upon any facts that might have occurred prior to the effective date of this Agreement whether known to either party now or discovered by either party hereafter.

8. No Admission of Liability. Employer and Employee agree that this Agreement and the payment by Employer of the consideration described herein is not an admission by Employer, Employer Releasees or Employee of any wrongdoing or liability. All parties specifically deny any liability; wrongful acts; violations of any federal, state, or local law, regulation, order, or other requirement of law; breach of contract (actual or implied); or any other civil wrong. The parties have entered into this Agreement in order to settle all disputes and differences between them, without admitting liability or wrongdoing by any party.

9. Confidentiality. This Agreement shall remain confidential as a personnel record to the extent permissible by Government Code Section 6254(c). In the event a Public Records Act request is made to review and/or copy this Agreement, Employer's only obligation shall be to timely notify Employee of that request. Employer shall not be obligated to incur legal expenses to deny such a request.

10. References. If Employee requests an employment reference from Employer, Employer shall only provide the Employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Employer's Human Resources Department.

11. Non-Disparagement. Employer and Employee each warrant and agree that he/she/it will not disseminate, orally or in writing, any comments which are in any way negative about, or disparaging to the other, or to the other's representatives or Employees, individually or collectively.

12. Employer Property. On Employee's Separation Date, Employee agrees to return all Employer property, including, but not limited to: keys; key cards; equipment and supplies; electronic and physical documents and files; and all confidential, private, and proprietary documents and files. Employee also agrees to continue to comply with CalOptima Policy GA 8050: Confidentiality, which is incorporated into this Agreement herein by reference, even after the Separation Date.

13. Construction. This Agreement has been negotiated and discussed between the parties and it reflects their mutual agreement regarding the subject matter of this Agreement. Neither party shall be deemed to be the drafter of this Agreement. Therefore, no presumption for or against the drafter shall be applicable in interpreting or enforcing this Agreement.

14. Separability. If any provision of this Agreement, or the application thereof to any person or circumstance, is found to be invalid, the remainder of the provisions of this Agreement, or the application of such provisions to persons or circumstances other than those which it is found to be invalid, as the case may be, shall not be affected.

15. Advice of Counsel. Employer has advised Employee to consult with a private attorney prior to executing this Agreement. Employee fully understands the right to discuss all aspects of this Agreement with a private attorney and has had reasonable and sufficient time and opportunity to consult with an attorney. Employee has either consulted with an attorney of his or her own choosing or has elected to enter into this Agreement without consultation with an attorney despite Employer's advice to consult with an attorney. Employee has had sufficient time to read and consider the terms of this Agreement, fully understands all of the provisions of this Agreement and is freely and voluntarily entering into this Agreement.

16. Complete Agreement. This is the entire agreement between Employer and Employee with respect to the subject matter herein and this Agreement supersedes all prior and contemporaneous oral and written agreements and discussions.

17. Acknowledgment of Days to Consider. Employee has been advised of the right to consider this Agreement for up to twenty-one (21) calendar days prior to its execution and has either: (a) been provided the full period to consider the agreement; or (b) voluntarily waived the full period, electing with full knowledge and consent to execute this Agreement as of the date indicated on the signature line of this Agreement.

18. [USE ONLY for RIF of 2 or more employees] Summary of Considerations. The classification, department, or group of individuals covered by CalOptima's reduction in force (RIF) includes all employees in the [describe impacted location, area, department, line of business, etc., (e.g. CalOptima, Human Resources, PACE, OneCare, etc.)] whose employment is being terminated in the RIF during the following period (XX/XX/XXXX to XX/XX/XXXX). All employees in [describe impacted location, area, department, line of business, etc., (e.g. CalOptima, PACE, OneCare, etc.)] whose employment is being terminated are eligible for the RIF.

The following is a listing of the ages and job titles of employees who were and were not selected for layoff [or termination] and offered consideration for signing the waiver. Except for those employees selected for layoff [or termination], no other employee is eligible or offered consideration in exchange for signing the waiver:

Job Title	Department/Unit	Age	# Selected	# Not Selected

19. Revocation. Employee may revoke this Agreement for a period of seven (7) calendar days following its execution. Said revocation must be in writing, must specifically

revoke this Agreement, and must be received by the Executive Director of Human Resources, at Employer's premises, prior to the end of the seventh day following Employee's execution. Upon expiration of the seven (7) calendar day period, this Agreement becomes effective, enforceable and irrevocable. If Employee has not delivered written revocation of this Agreement to Employer within said seven (7) calendar day period, Employee will receive the consideration described in paragraph 2 above.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, Employee acknowledges that Employee has been advised to **CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT AND GENERAL RELEASE**, and Employee understands that by signing this Agreement and General Release, Employee is giving up and waiving important legal rights. Nevertheless, Employee and Employer mutually agree to the terms above, and hereby execute this Agreement on the day and year last shown below.

"EMPLOYER"

Date: _____ _____

By: Richard Sanchez
Its: Chief Executive Officer

"EMPLOYEE"

Date: _____ _____

By:_____
(print name)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Richard Sanchez, Chief Executive Officer, (657) 900-1481

Recommended Actions
Elect one member of the CalOptima Board of Directors (Board) to serve as Board Chair, and one to serve as Vice Chair for terms commencing on January 1, 2021 and running through June 30, 2021, 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.

The Board typically holds its organizational meeting in June and conducts its annual election of officers at that time. However, due to a number of Board members completing their service at the June 2020 meeting and other factors, officer elections were held at the Board's September 3, 2020 meeting for terms ending December 31, 2020. At this time, staff recommends that the Board consider electing officers for terms commencing on January 1, 2021 and running through June 30, 2021, the last day of CalOptima's current fiscal year.

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 *11/24/2020*
Authorized Signature **Date**

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Board of Directors Meeting
December 3, 2020

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

At the October 22, 2020 OneCare Connect Member Advisory Committee (OCC MAC) meeting, the members welcomed Meredith Chillemi as the Long-Term Care Representative.

Richard Sanchez, Interim Chief Executive Officer, updated the committee on the possible rate reductions that were announced in September 2020. He noted that the Department of Health Care Services (DHCS) had notified CalOptima the Medi-Cal Expansion rate cuts would not be as large as anticipated and that the DHCS has agreed to work with CalOptima on the requested glidepath for these rate reductions.

David Ramirez, M.D., Chief Medical Officer, notified the committee that CalOptima had received a quality award for being the only Medi-Cal plan in the state to perform above percentile benchmark in all the quality measures for Reporting Year 2020 using 2019 statistics. He noted that, while this award was not for OneCare Connect, it was indicative of the quality of care CalOptima provides to all of its members.

Ladan Khamseh, Chief Operating Officer, provided an update on the current network certification requirements and the Qualified Medicare Beneficiary (QMB) outreach.

The committee also received an OCC MAC Transition Planning update by Ravina Hui, Director, Program Implementation, a Federal and State Legislative update by TC Roady, Director, Regulatory Affairs, and a presentation on OCC Benefit Changes for 2021 by Andrew Tse, Manager, Customer Service.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Board of Directors Meeting
December 3, 2020

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

At the October 27, 2020 Whole-Child Member Family Advisory Committee (WCM FAC) meeting, the members received an update from Richard Sanchez, Interim Chief Executive Officer, who updated the committee on the possibility of a Medi-Cal Expansion rate reduction that had been announced by the Department of Health Care Services (DHCS) in September. He noted that recently, DHCS had notified CalOptima that the Medi-Cal Expansion rate cuts would not be as large as anticipated, and that DHCS has agreed to work with CalOptima on the requested glidepath for these rate reductions. Mr. Sanchez also informed the committee that CalOptima had recently been recognized by DHCS for meeting quality metrics set by the state, and that CalOptima was the only plan in California to meet all of the established metrics.

Committee members received a verbal update on DHCS's California Children Services Advisory Group (CCS AG) meeting and a presentation on the California Children Services (CCS) Aging Out Transition from Tracy Hitzeman, Executive Director, Clinical Operations. Kristin Gericke, Director, Pharmacy Management, provided the members with an update on the Medi-Cal Rx transition to Magellan Health Care, which is slated to be effective January 1, 2021.

The Committee also received a Chief Medical Officer update from David Ramirez, M.D., who provided a brief update on the activities of the Whole-Child Model Clinical Advisory Committee. Jackie Mark, Sr. Policy Advisor, Government and Legislative Affairs, provided a Federal and State Legislative update.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the WCM FAC's current activities.

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Board of Directors Meeting
December 3, 2020

Provider Advisory Committee (PAC) Update

On November 12, 2020, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

Richard Sanchez, Chief Executive Officer, provided a CEO report and notified the committee that Board Member Jackie Brodsky had resigned her seat due to family issues. Ms. Brodsky has served in the member/family member of a member seat on the Board Mr. Sanchez noted that the Orange County Health Care Agency was undertaking a special recruitment to fill her seat, and he asked the PAC to share the news to promote the recruitment.

Ladan Khamseh provided a Chief Operating Officer update after congratulating Richard Sanchez on his official appointment as CalOptima's CEO. She informed the PAC that approximately 1,000 members had been mailed information on their possible eligibility for the Qualified Medicare Beneficiary program to claim Part A Medicare benefits. She also provided an update on the current status of the Medi-Cal Rx program and noted that Magellan Health Care has begun sending the 90 and 60-day notices to members and that CalOptima is responsible for the final 30-day notice. Ms. Khamseh also notified the PAC about the Virtual Care Innovation Network grant funding that may be available to providers. She noted that CalOptima providers had been sent information on the Virtual Care Innovation Network.

David Ramirez, M.D., Chief Medical Officer, shared with the committee that CalOptima had received a quality award from the Department of Health Care Services (DHCS) for being the only Medi-Cal plan in the state to perform above percentile benchmark in all the quality measures for Reporting Year 2020. He thanked the providers for their assistance in achieving this honorable award. Dr. Ramirez provided a brief update on Medi-Cal Rx and noted that the All Plan Letter (APL) had been released and there were not significant changes. He also discussed the Orange County Coronavirus Taskforce and provided an update on the promising vaccine development results that were recently announced. He noted that the taskforce would be reviewing ways to promote the vaccine to CalOptima members and others in the community.

Elizabeth Lee, PACE Director, provided an informative update on PACE activities during COVID to the Committee. The Committee also received an update on the OneCare Connect Transition Planning from Ravina Hui, Director of Program Implementation, as well as a Federal and State Legislative update from Jackie Mark, Sr. Policy Advisor, Government Affairs.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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Board of Directors Meeting
December 3, 2020

Member Advisory Committee Update

November 12, 2020

At the November 12, 2020 Special Member Advisory Committee (MAC) meeting, members voted to recommend appointment of Jacqueline Gonzalez to the MAC as the Recipients of CalWORKs Representative.

Richard Sanchez, Chief Executive Officer, reported on COVID-19. He also noted that Board Member Jackie Brodsky, who represented Members, had resigned her seat on the Board due to family reasons. He noted that the Orange County Health Care Agency would coordinate the recruitment effort to fill this Board seat, and asked the MAC to help recruit for this opening by sharing this information with their constituents.

Ladan Khamseh, Chief Operating Officer, reported on the Qualified Medicare Beneficiary outreach that began earlier in November. She noted that over 1,000 CalOptima members were sent letters notifying them that they may qualify for Medicare Part A benefits. The letters contain information on how to apply for this benefit. Ms. Khamseh also provided a brief update on the Medi-Cal Rx transition.

David Ramirez, M.D., Chief Medical Officer, shared with the committee that CalOptima had received a quality award from the Department of Health Care Services (DHCS) for being the only Medi-Cal plan in the state to perform above percentile benchmark in all the quality measures for Reporting Year 2020. He also referenced the Orange County Coronavirus Taskforce and provided an update on the promising vaccine development results that have been recently announced. He also noted that the taskforce would be reviewing ways to promote the vaccine to CalOptima members and would provide updates to the committee as they become available. Dr. Ramirez also provided an update on Telehealth and E-Consults and noted that Telehealth was undergoing an RFP process and that staff would provide updates in the near future on this item.

MAC members also received information on the OneCare Connect Transition Planning from Ravina Hui, Director, Program Implementation. In addition, Jackie Mark, Sr. Policy Advisor, Government Affairs, provided the MAC with a Federal and State Legislative update.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's current activities.

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